TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. certificate be executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| 14- | | THE TOTAL OF | VEL 3 FINALL | 7 vilas | UUUU |
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| VI. | PLACE DF DEATH a. CDUNTY | LUCIA 7 LALARI O | | E (Where deceased lived, If in b. COUI | stitution: Residence before admission) |
| | ALLEGANY | MARYLAND | a. STATE MA | RYLAND | ALLEGANY |
| | b. CITY OR TOWN (if outside corporate limits, | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If | outside corporate limits, w | rite RURAL end give nearest town) |
| | write RURAL and give nearest town) CUMBERLAND | 18 DAYS | CUMBERL | AMD | 11.1 |
| - | d. NAME OF HOSPITAL OR INSTITUTION (if not in i | | d. STREET ADDRESS | AIND | e. IS RESIDENCE |
| | Control of the contro | | 001 000 | | ON A FARM? |
| = | SACRED HEART HOSPITAL | | | GRUDER ST. | YES NO |
| 3. | NAME DF FIrst DECEASED | Middle | Last | 4. DATE Mont | |
| _ | (Type or print) DENEEN NM | | | | /67 19 |
| 5. | SEX 6. COLDR OR RACE 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| | MALE N WIDOWED | D DIVORCED | 8/6/96 | 70 71 yrs. | Mondis Days Hours Minn |
| 10 | | KIND OF BUSINESS OR | 11. BIRTHPLACE (C | ounty & State, or foreign country | y) 12. CITIZEN OF WHAT COUNTRY? |
| 17 | Soll Lan | INDUSTRY | Rumb | erland | II CA |
| 1 | B. FATHER'S NAME | policy . | 14. MOTHER'S MAIL | DEN NAME | a.d.r. |
| | ANDREW BANKS | | SUSAN | / Un house | 1,000 |
| 1 | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 | S. SOCIAL SECURITY NO. 17. | INFORMANT | Addre | ess |
| 0 | es, no, or unkown) (If yes give war or dates of service) | | TOTAL OFFICE | om | |
| - | 70 | | PT'S. CHA | (CI, | |
| | 18. CAUSE OF DEATH [Enter only one cause per | line for (a), (b), and (c).] | | 000 | / INTERVAL BETWEEN ONSET AND DEATH |
| | PART I. DEATH WAS CAUSED BY: | mount pull | undue , | askerators | type 9 day |
| | 33dA DUE TO | | | | 3 0 |
| | Cenditions, If any, which) (b) | Paralepsod. To | noal | | 7 days |
| | gave rise to Immediate (cause (a), stating the DUE TO | 11/1/2 | 0 0 0 | | 541 |
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| E | 20a. ACCIDENT WAS UNDERLYING 20b. | DESCRIBE HOW INJURY OCCU | IRRED. (Enter nature of | Inlury in Part I or Part II | |
| CERTIFICATION | DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 1 | | INUIDY COOLIDATE LOSS DI A | OF OF INHIBY/Hemp for | arm, 20f. (City or town) | (County) (State) |
| MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. Hour a.m. | facte | CE OF INJURY (Home, fary, street, office bidg., e | (C.) | (Godina) |
| MEL | p.m. 19 at wo | | 0 | 1 | |
| | 21. I certify that (I) (this hospital) attend | ded the deceased from | Re L/1 | 9 00 to 2 fac | 1, 19 67, that (I) (we) last |
| | | Long / 573 | death occurred | M, from the causes | and on the date stated above. |
| | 22a. SIGNATURE | | \/ | | 22b. DATE SIGNED |
| | 1 musi | eeden M.C | | MED. STAFF DIRECTOR PHYS. | 23 ples 6/ |
| | 22c. PHYSICIAN'S | | 22d. ADDRESS | / / | land, hust |
| | NAME (Type) DR. WEISMAN | | 59 01 He | end & aller Der | land, mil |
| 23 | Ba. BURIAL, CREMATION, 23b. DATE THEREOF | 23c. NAME OF CEMETERY | OR CREMATORY | 23d. LOCATION (City, t | town or county) (State) |
| | REMOVAL (Specify) | Rose Id | el Cam | Quale 1 | and MA |
| 2 | 4. FUNERAL DIRECTOR | ADDRESS | 25a, RE | C'D BY REGISTRAR 25b. R | EGISTRAR'S SIGNATURE |
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 24 hours after death. PLACE OF OEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY s. Pages 1 hours after Allegany Allegany Marvland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b by 50 Years = Cumberland Cumberland etely filled In bon papers. within 72 ho d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 6. IS RESIDENCE Sacred Heart Hospital 223 Pear Street NO X YES completely i within NAME OF Last DATE Middie Month Day Year **OECEASEO** event, Amos Samuel Bennett 1 26 19 67 OFATH (Type or print) 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED remove 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNOER 1 YEAR | IF UNOER 24 HRS. | last birthday) | Months | Days | Hours | Min. any and 2/25/98 Male White WIOOWEO DIVORCED attending physician a srmit. Then please re C 10a. USUAL OCCUPATION (Give kind of work done i 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) West Va. USA retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Maud Nelson Bennett Floyd Bennett 15. WAS DECEASED EVER IN U.S. ARMEO FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) death igned by the att rial-transit perm rial, cremation, o 217-10-6224 patient's chart 18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that ti Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) been s. DUE TO Cenditions, If any, which gave rise to immediate as the prior to DUE TO cause (a), stating the underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY certificate his hed for use a t. of Health p PERFORMEO? YES NO 208. ACCIOENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF BEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury)h Part I or Part II of Item 18.) hed f MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Not While factory, street, office bldg., etc.) Hour a.m. After Id be d at work p.m. at work DIRECTOR: A age 3 should lied with the 3 21. I certify that (I) (this hospital) attended the deceased from 194 and that death occurred at 5.55 M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. OATE SIGNEO page STAFF DIRECTOR TO FUNERAL director, pa should be fil PHYSICIAN'S 22d. ADDRES NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) REMOVAL (Specify) Burial 30 Jan 67 Rest Lawn Memerial Gardens 24. FUNERAL DIRECTOR **ADDRESS** 25a. REC'D BY REGISTRAR SILCOX FUNERAL SERVICE 404 Decatur St., Cumberland VR A15 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00004 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. STATEMARY LAND o. COUNTY b. COUNTY ease remove carbon popers. Pages 1 and in any event, within 72 hours after ALLEGANY MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAL and give neorest town) 28 DAYS CUMBERLAND. MD. d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not inhospital, give street oddress) completely filled in 718 WASHINGTON ST. NOT 3. NAME OF Middle 4. DATE Month Lost Doy Year DECEASED SARAH BERNSTEIN JANUARY 67 19 (Type or print) DEATH S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In yeors IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** lost birthdoy) Hours 11-27-76 WHITE FEMALE WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) disposed of workinglife, even it extred) INDUSTRY COUNTRY? U.S.A. 13. FATHER'S NAM 14. MOTHER'S MAIDEN NAMI buriol, cremotion, or remove GOLDENBERG 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN Address (Yes, no or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL CUMBERLAND, MD. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by Poge 4 may be retained by the hospitol or ottending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO for use os the b Heolth prior to b stoting the underlying couse **DIRECTOR:** After this certificate has been WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? NO 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) be detached for Stote Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor foctory, street, office bldg., etc.) Hour o.m. Not While 19 director, page 3 should be should be filed with the Stot 21. I certify that (I) (this haspital) attended the deceased from_ 195 and that death accurred as O M. from couses and an the date stated above. saw the deceased plive of 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S O FUNERAL CUMBERLAND. NAME (Type) DR. B. SCHINDLER ST., 23c. NAME OF CEMETERY OR CREMATORY (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOS LOCATION (City or Town) (County) MOVAL (Specify) REGISTRAR'S SIGNATURE 25o. REC'D BY Carles DATE

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partycicion and completely filled in by the funeral ren eleose remove corbon papers. Pages T and 2 oval, and in any event, within 72 hours after eleoth.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after deoth.

MARYLAND STATE DEPARTMENT OF HEALTH

| | | Division of STATISTICA | IL KESEA | KCH AND KECOKDS | , 301 | M. LKEZION ZIKE | EI, BALIIMORE | , MAKYLAN | ID 21201 | |
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| | 00005 | | | CERTIFIC | ATE | OF DEATH | | | 0000 | 5 |
| 1. | PLACE OF DEATH | | | 46 | | 2. USUAL RESIDENCE (| Where deceosed lived | | Residence before | e admission) |
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| | | give nearest tawn) | | 14 DAYS | | DT 2 D | ov lo | HADED | LAND | MD AL |
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| | (Type or print) | ISAAC | | M | | BOORE | OF DEATH | JAN | 9 | 19 67 |
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| 10 | a. USUAL OCCUPATION | (Give kind af wark dane | | ID OF BUSINESS OR | | 11. BIRTHPLACE (County | & State, ar fareign ca | untry) | 12. CITIZEN OF | WHAT |
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| | . FATHER'S NAME | 11. | | 2.1. | | 14. MOTHER'S MAIDEN | | | | |
| | WILLIAM | ROORE | | | | MARGA | | र मः | | |
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| _ | 110 | | | 48 6544 | IAIE | MORIAL H | USPITAL | CU | | ND, MD. |
| | 18. CAUSE OF DE | ATH (Enter anly ane cause p H WAS CAUSED BY: | | | Un. | O . OP | 0000 | | | RVAL BETWEEN SET AND DEATH |
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| | Conditions, if ony, | which gove) (b) | a | itenogles | fer | has de | seece c | facle | 9 | 3 months |
| | rise to immediate | cause (o), | | 71 | - | | | / | 2 | P |
| | stating the under | lying cause (c) | 5 | respected | Ca | relichen a | tosas | | | uneter. |
| | | SNIFICANT CONDITIONS CONTR | NOUTING T | O DEATH BUT NOT BELATER | TO Th | IF TEDAMAIA DISEASE COM | UDITION CIVEN IN DA | DT 1/a\ | 110 | WAS AUTOPSY |
| IFICATION. | PART II. UTHER SIG | efelioze 6-0- | | U DEATH BUT NOT KELATEL |) IU Ir | IE TERMINAL DISEASE COR | NUTTION GIVEN IN PA | KI I(d) | | PERFORMED? |
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| <u>R</u> | 20o. ACCIDENT WAS OR CONTRIBUTING | | 20b. DES | CRIBE HOW INJURY OCCUR | RRED. (E | inter nature of injury in | Part I ar Part II of it | em 18.) | | |
| 7 | (IF EITHER, NOTIFY | MEDICAL EXAMINER) | | | | | | | | |
| MEDICAL | 20c. TIME OF INJU | RY Month, Day, Year | 1 | | e. PLACE | OF INJURY (Home, farm ry, street, affice bldg., etc.) | n, 20f. (City o | r tawn) · | (County) | (State) |
| ME | p.m | 10 | While at wark | Nat While at work | luciu | y, sileer, diffice blug., etc., | , | | | |
| | 21. I certif | y that (I) (this haspita | I) attend | led the deceased fra | m | , 1 | 19 <u>77</u> , ta | 119 | , 19 46, th | at (I) (we) las |
| | saw the | espașed alive an | 1/9 | 19 <u>66</u> , and | that | death accurred 2t | :25PM, fram | r causes and | an the dat | e stated abave |
| | 22a. SIGNATURE | Marine | 4 | | | ATTENDING | MED. | TAFF | 22b. DATE SIGN | ED /17 |
| | 19 | mesu | alr | | M.D. | PHYS. | | HYS. | 1/10 | 161 |
| | 22c. PHYSICIAN'S | 22 6 6 | 1.15.1.6 | 214011 | | 22d. ADDRESS | ENE 0= | 011145 | | 1.450 |
| | NAME (Type) | DR. S. G. | WEIS | MAN | | 59 GRE | ENE ST., | COMP | ERLAND | , MD. |
| 23 | a. BURIAL, CREMATIO | N, 23b. DATE THEREO | F | 23c. NAME OF CEMETER | Y OR C | REMATORY | 23d. LOCATION | (City or Town) | (County) | (state) |
| | REMOVAL (Specify) | JAN. 12, | 1967 | BURNING BU | SH | CEMETERY | ROUTE 3 | BEDFO | RD, PA. | MILE |
| 2 | 4. FUNERAL DIRECTOR | ? | | ADDRESS | | | BY REGISTRAS | 2Sb. REGIS] | RAR'S SIGNATUR | edak. |
| | BYRON | KIGHT | CT | IMBERLAND, M | D. | DATE | 1 10 1301 | 1 | a som | |

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TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending director, page 3 should be detoched for use os the buriol-tronsit permit. In should be filed with the State Dept. of Health prior to buriol, cremotion, or reference to the state of the s

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00006CERTIFICATE OF DEATH certificate be executed within 24 hours after death ve carban papers. Pages 1 and event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH b. COUNTY ALLEGANY O. COUNTALLE GANY o. STATE MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, DAYS CUMBERLAND. MD. filled in I e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS MEMORIAL HOSPITAL 106'S ARCH STREET YES NO X 3. NAME OF Middle DATE Lost Month Doy Year campletely DECEASED VERNON Α. BRINKMAN 19 67 JANUARY (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Dovs Hours WHITE 7-30-20 MALE DIVORCED WIDOWFD 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) Textile COUNTRY? MARYI AND - CUMBERLAND U.S.A. Recovery Dept. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar remaval PERRY BRINKMAN LAVERNIA MANN 16. SOCIAL SECURITY NO. 17. INFORMANT Address PHYSICIAN: The law requires that the death 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 212-18-1955 MEMORIAL HOSPITAL CUMBERLAND. MD. War ves INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) by Page 4 may be retained by the haspital ar attending physician. DUE TO bec. 18, 1966 Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse FUNERAL DIRECTOR: After this certificate has been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES T NO far 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) Not While foctory, street, office bldg., etc.) Hour o.m. 19 ot work ot work . 196 (that (1) (we) last , 1966 ta directar, page 3 shauld shauld be filed with the 1967, and that death accurred at: 15AM, fram causes and an the date stated abave. saw the deceased alive ans 22o. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR PHYS. M.D. 22d ADDRESS 22c. PHYSICIAN'S CLAY DURRETT 236 VA. AVE. . CUMBERLAND. MD. NAME (Type) DR. 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Jan.6,1967 Sunset Memorial Park Cumberland, Md. Allegany 0 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR nayees VR A15 (4) 20 M 1/66 DATEAN 1967 James F. Scarpelli, Cumberland. Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00002 CERTIFICATE OF DEATH funeral 1 ond 2 ter death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY o. COUNTY ALLEGANY ALL EGANY MARYL AND MARYLAND mave carban papers. Pages I any event, within 72 haurs after b. CITY OR TOWN (If autside carparate limits. C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) CUMBERED AND POTEST town) CUMBERLAND e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (ILL not in hospital, give street address) MEMORIAL YES | NO D **ELEANOR** First 4. DATE Year 3. NAME OF Middle CAPPER Manth 67 OF JANUARY DECEASED 19 (Type ar print) DEATH B. DATE OF BIRTH 9 AGE (In years last by theay) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 7. MARRIED **NEVER MARRIED** Manths Days Haurs FEMAL E X DIVORCED WIDOWED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 10a. USUAL OCCUPATION (Give kind.af work done during most af warking life, even retired) COUNTRY?A INDUSTRY CUMBERLAND. MD. Housewif 14. MOTHER'S MAIDEN NAME PATHER'S NAME crematian, or remayal, JAMES COOK ANNIE R. SMITH 17 INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, prunknown) (If yes give war or dates of service CUMBERLAND. MD. MEMORIAL HOSPITAL. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO burial. Canditians, if any, which gave rise ta immediate cause (a) DHF TO stating the underlying cause as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Health 1 NO YES T 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II af item 1B.) 20o. ACCIDENT WAS UNDERLYING detached f te Dept. af I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Not While Haur a.m. at wark ot wark 21. I certify that (I) (this hospital) attended the deceased fram, directar, page 3 shauld shauld be filed with the M, fram causes and an the date stated above. and that death accurred at saw the deceased glive and 22a. SIGNATURE DATE SIGNED STAFF PHYS. MED. DIRECTOR M.D. PHYS. CUMBERLAND, MD. 22c. PHYSICIAN'S SCHINDLER BLANE DR. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY (State) 23d, LOCATION (City or Tawn) (County) 23a. BURIAL, CREMATION, 23b. DATE THEREOF DEMOVAL (Specify) REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66

The law requires that the death certificate be executed within 24 haurs after death.

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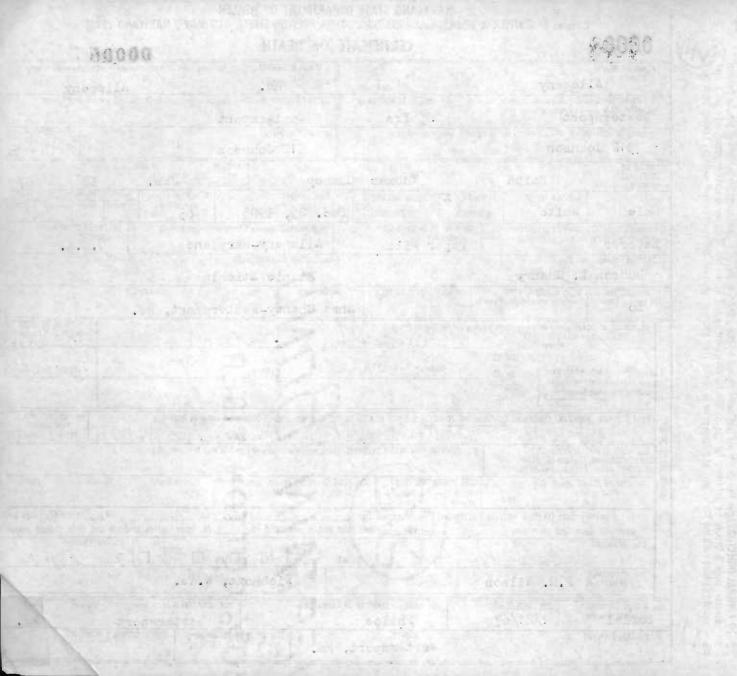
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 80000 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death campletely filled in by the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Allegany Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) ve carban papers. Pagevent, within 72 haurs Yrs Westernport d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? 512 Johnson 512 Johnson YES NO SC remave carban 3. NAME OF First Middle DATE Last Month Year Doy DECEASED Ralph Thomas Chaney Jan. 18 67 (Type or print) DEATH 19 S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last_birthday) Hours Male White Dec. 23, 1903 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) edse Paper COUNTRY? Allegany-Maryland Mi 11 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending phy burial-transit permit. Then Hudson L. Chaney Minnie Stienla IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no or unknown) (If yes give war ar dates af service) Anna Chaney-Westernport, Md. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: NTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) attending physician. DUE TO Psychnonerros13 Conditions, if ony, which gove rise to immediate cause (a), DUE TO stoting the underlying cause as the has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO X O FUNERAL DIRECTOR: After this certificate YES TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the haspital ar far 20a. ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour a.m factory, street, affice bldg., etc.) Nat While at wark at work 21. I certify that (1) (this haspital) attended the deceased fram July 1960, to Jun 18, 1967, that (I) (we) last Jan 2 19 67, and that death occurred at QAM, fram causes and an the date stated above. saw the deceased alive on_ 22a. SIGNATURE 22b. DATE SIGNED ATTENDING director, page s chould be filed v DIRECTOR M.D. ADDRESS W. Va. 22d. 22c. PHYSICIAN'S P.R. Wilson NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Store) BREMOVAL (Specify) 1/21/67 Philos Westernport Md. ADDRESS 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Westernport, Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00000 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY O. STATE MARYLAND b. COUNTY 0 PM3. Page of MARYLAND ALLEGARY delay and 3 t b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b. CUMBERLAND MIDLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS with the State Dep within 72 hours a IS RESIDENCE ON A FARM? form in Item 18. Give Poges 1, SACRED HEART HOSPITAL BOX 136 NO 3. NAME OF First Middle Lost 4. DATE Month Doy Year DECEASED Clarke DEATH JANUARY 1967 (Type or print) Marshall 22 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours MALE WHITE 3-7-19 WIDOWED DIVORCED event This certificate should be executed within 24 hours 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired).

Construction Work **INDUSTRY** COUNTRY? pages I S.A. MIDLAND, MD. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME CLarke ROBERT BERTIE (CUTTER) File WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. 4 should be forworded to the Chief Medical ar remaval, pending PT'S CHART 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY HOURS DEATH SUBDURAL HEMORRHAGE. RIGHT IMMEDIATE CAUSE (o) used os a buriol-troi burial, cremotion, a writing the word DUE TO Conditions, if ony, which gove RUPTURE OF CONGENITAL ANEURYSM OF rise to immediate couse (o), RIGHT POSTERIOR CEREBRAL ARTERY DUE TO stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? the certificate, be to YES NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) ogent, prior plnods PRIMARY Or CONTRIBUTING AL EXAMINER: CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Doy, Yeor 20e. PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour o.m. moy be retoined far your FUNERAL DIRECTOR: Page Not While factory, street, office bldg., etc.) 19 the funeral director. Page of work designoted 21. I certify that I taak charge af the remains described above, held an Autopsy Inspection XX, Inquiry X and in my opinian deoth resulted fram: Notural causes Suicide . Undetermined manner Accident | | Hamicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY January 22, 1967 DEPUTY MEDICAL EXAMINER EXAMINER'S Heolth (NAME (Type) BENEDICT Address (Street, city, town, or county) Cumberland. Md. SKITARELIC 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 50 Burial Sunset Memorial Park Cumberland, 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR DATE JAN 25 24. FUNERAL DIRECTOR ETCHHORN Lonaconing. JAN VR A15ME (5) 6M 1/66

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) e. COUNTY files. Health, b. COUNTY Allegany

b. CITY OR TOWN (if outside corporete limits, Maryland Allegany MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ector. write RURAL and give neerest town) Midland Midland State Board d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE for ON A FARM? retained YES NO X death. 3. NAME OF First Middle 4. DATE Month Dev Year DECEASED OF (Type or print) DANTEL COLEMAN DEATH 19 with th 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 2 witl last birthdey) Months Male WIDOWEDY DIVORCED 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? Page Retired (Celanese USA Midland, MD. Pages 1 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John S. Coleman Ellen Tighe 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT certificate should be executed withi Address (Yes, no, or unkown) | (Ifyes give wer or detes of service) permit John R. Jones Midland, MD. with (Step-Son) 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN I-transit p Sudden I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Coronary Occhusion in pencil Office DUE TO burial Coronary Sclerosio Conditions, if eny, which (b) "pending" geve rise to immediate ceuse Examiner's (DUE TO (a), steting the underlying 0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 3 cremat writing the word Medical NO plnods 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) PRIMARY Or CONTRIBUTING EXAMINER: Chief 20c. TIME OF INJURY Month, Dey, Yeer 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) 966 fectory, street, office bldg., etc.) While Not While Hour e.m. the R: P: et work et work 21. I certify that I took charge of the remains described above, held an Autopsy 1. Inspection A Inquiry A and in my opinion 0 should be forwarded to FUNERAL DIRECTO Natural causes A Suicide Homicide Undetermined manner death resulted from: CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY Cumberland, cillon, or county) Benedict 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or country) (Stete) REMOVAL (Specify) 940 g St. Josephs Cemetery 0 Midland, MD. Burial 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE ADDRESS 23. FUNERAL DIRECTOR 1967 VS. AISME Lonaconing, MD. 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH and 2 be executed within 24 haurs after death and campletely filled in by the funeral remave carban papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH b COUNTY o. COUNTY o. STATE ALLEGANY MARYLAND ALL FGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 DAYS CUMBERL AND d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) NO X YES T - L Year 6 3 NAME OF 4. DATE First Middle CONWAY JANUARY F DECEASED ETTA DEATH (Type ar print) S SEX 6. COLOR OR RACE WHITE DATE OF BIRTH AGE (In years IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED Months FEMALE Dovs Hours 7-26-78 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired INDUSTRY S.A. FREDERICK. MD. requires that the death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME CHRISTOPHER BOOGHER HANNAH C. FLORA 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. permit. (Yes, no. or unknown) I(If yes give wor or dotes of service ь MEMORIAL HOSPITAL. CUMBERLAND. MD. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: signed by DUE TO Conditions, if ony, which gave rise ta immediate cause (a), DUE TO stoting the underlying couse has been as the lost WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES TO NO O FUNERAL DIRECTOR: After this certificate Į. 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Hour a.m. Not While 198:0,50 P.M. 21. I certify that (1) (this haspital) attended the deceased fram 1,23,6 be retained 19 67, and that death accurred at M, from causes and on the date stated above saw the deceased alive an shaul 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. DIRECTOR directar, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S F. WILLIAMS CUMBERLAND. MD. W. NAME (Type) DR. 23o. BURIAL CREMATION. 23c. NAME OF CEMETERY OR CREMATORY 23d_ LOCATION (City or Town) (County) (Stote) 23b DATE THEREO REMOVAL (Specify) 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR DATE A

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00012 CERTIFICATE OF DEATH 00012 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death the attending physician and completely filled in by the funeral sit permit. Nien please remove carban papers. Pages I and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH Allegany b. COUNTY Allegany o. COUNTY Maryland lease remave carban papers. Pages 1 and in any event, within 72 haurs after MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumber Land 1966 Cumberland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary 217 Carroll Street YES NO IX 3. NAME OF Middle 4. DATE First Lost Month Doy Year DECEASED Bessie Louise Davis 21 January 19 67 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 92 birthdoy) Months Hours Dovs 8/9/1874 WHITE Black IDOWED K Female DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
Housewife TOUNTRY? INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Baker Daniel Banks Elizabeth Robinson Addres Cumberland . Md IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no or unknown) (If yes give wor or dotes of service) 219-54-1207 Allegany County Infirmary records 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN accepating. Decele burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been prior to as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 118 19. WAS AUTOPSY PERFORMED? use MEDICAL CERTIFICATION Health YES NO Por 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. Hour o.m. Not While foctory, street, office bldg., etc.) 19 ot work ot work should be 1967, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from ______ 19 6 7, and that death occurred at P • M, from causes and an the date stoted above. saw the deceased alive an MED. DIRECTOR 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. K director, page 3 should be filed v M.D. PHYS 22d. 22c. PHYSICIAN'S O HOSPITAL St., Cumberland, Mathews, Greene M. NAME (Type) Lee 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) 23o. BURIAL, CREMATION, REMOVAL (Specify) Md 967 Woodlawn Cemetery Cumberland Alleg. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 20 M 1/66 John J. Balto Ave. CumberlandATE JAN Hafer.

C COOK. TERRITA. Ballfard Company of the State o torris from the Sisteman from the Sisteman and the second Passic London Paris TRANSCOND TO THE TRANSCOND OF THE STATE OF T The first from Francisco Control of the Contr August Ingist Comics and Aller of Commission of the Commission of . in come transfer to the transfer VIII-18 -019 had Of the state of th New 7, Maio-, Nr. 25 United two days on the last the party of the contract of

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| U | 5013 | | | CERTIF | ICATE | OF DEATH | | 00 | 013 | | | |
|---------------------|--|--|------------------|-----------------------------------|-----------|--|------------------|---------------------------------|---------------|-----------|---------------------------|--------------------|
| 0. (0 | E OF DEATH DUNTY | Allegany | | MARY | | 2. USUAL RESIDENCE (V o. STATE Mary) | and | b. COU | A] | lega | ny | on) |
| | | outside corporate lim give nearest town) | its, | c. LENGTH OF STAY II | | c. CITY OR TOWN (If ou | | e limits, write RU | RAL ond gi | ve neares | t town) | |
| | onoconi | | | 3 Years | 5 | | ptown | | | 01 | 15 0550 | DENICE |
| | | or institution (if i | not in hospitol, | give street oddress) | | d. STREET ADDRESS | | | | | e. IS RESID ON A FA | ARM? |
| 3. NAM | E OF ASED | | First | Middle | | Lost | 4. DATE OF | Mon | th | Doy | Уес | ar |
| (Type | e or print) | M | ary | | Defi | finbaugh | DEATH | Janu | | 12 | | 67 |
| . SEX | | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | | B. DATE OF BIRTH | 9. | AGE (In years lost birthdoy) | Months Months | Doys | Hours | R 24 HRS Min. |
| emai | le | White | WIDOWED | DIVORCED | | June 13,1892 | | 74 Yrs. | | | | Will. |
| Oo. USU during m | ALOCCUPATION OF THE PROPERTY O | Give kind of work don le, even if retired) eper | | ND OF BUSINESS OR DUSIRY Home | | 11. BIRTHPLACE (County New York | | eign country) | 12. C | U.S. | | |
| 13. FAT | HER'S NAME | George St | ierstor | fer | | 14. MOTHER'S MAIDEN N | Page 1 | ary Hoff | man | | | |
| IS. WA | S DECEASED EVER | IN ILS APMED FORCES | 2 16 | SOCIAL SECURITY NO. | 17. 1 | NFORMANT | 110 | Addr | | | | |
| (Yes, po | , or unknown) (| If yes give wor or dotes | of service) | None _ | Воз | d D. Deffin | baugh | Cr | esapt | | | |
| 18. | PART I. DEATH | ITH (Enter only one of I WAS CAUSED BY: IMMEDIATE CAUS | N | (o), (b), and (c).) | | | | | 78 | ON | ERVAL BET SET AND D | DEATH |
| rise | ditions, if ony, to immediate ting the underl | which gove cause (o), | (b) (c) | rterios | lac | osis (| ene | ialyo | 9 | 4 | Zai | |
| PAF | RT II. OTHER SIG | NIFICANT CONDITIONS | CONTRIBUTING | TO DEATH BUT NOT REL | ATED TO 1 | THE TERMINAL DISEASE COM | IDITION GIVEN | N IN PART 1(o) | | | WAS AUTO PERFORM ES | OPSY NED? NO |
| OR (IE | | UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DI | SCRIBE HOW INJURY OF | CURRED. | (Enter noture of injury in I | Port I or Port | Il of item 18.) | | | | |
| MEDICAL 200 | . TIME OF INJUI Hour o.m p.m | 1/ | While | NJURY OCCURRED Not While of work | | CE OF INJURY (Home, form ory, street, office bldg., etc.) | | (City or town) | (0 | ounty) | | (Stote) |
| | 21. I certif | y that (I) (this ho | | ded the deceased | | | 9_60, to | | 12,19 | | | |
| | | ceased alive an_ | Jan | 10 1967, | and tha | t death accurred at | M | , fram causes | | | | d abay |
| 22 | o. SIGNATURE | TONE | rule | DE | | | MED. DIRECTOR | STAFF PHYS. | _ | DATE SIGN | B . P | 7 |
| 22 | c. PHYSICIAN'S NAME (Type) | L.R. | MIL | ESJR | | 22d. ADDRESS | DNA | CONLI | NG | M | D | |
| | JRIAL, CREMATIO | N, 23b. DATE T | HEREOF | 23c. NAME OF CEME | TERY OR | CREMATORY | 23d. LO0 | CATION (City or To | wn) | (County |) (5 | Stote) |
| BE | MOYAL (Specify) | 1/15/ | 67 | Sunset Me | mori | | Cumi | berland | Alle | gany | Mary | rlan |
| 0.4 | | | | 2220004 | | OC. DEC'T | DV DECICED | AD OCL D | PICTOADIC | CICMATHE | DE | |

TO FUNERAL DIRECTOR: After this certificate has been VR A15 (4) 20 M 1/66

Lee Silcox

Cumberland Maryland

Pages 1 and 2

physician and campletely filled in by the funeral

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the haspital ar attending physician.

director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar ta burial, cremations are maval, and in any event, within 72 hours after death

signed by the attending

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STAT MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. countyWashington Allegany a. STATE Virginia MARYLANO Department after death. cessary, funeral may be b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Barton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b 1 day Abington the 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ay . 3 to Page State hours 245 Barter Drive NO X YES 2, and PM3. 3. NAME OF First Middle Lest Month Day Year the 72 DECEASED S Henry Dennison Jan. 13 19 67 (Type or print) DEATH 2 with within death. If a Pages 1, 5. SEX Male 6, COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) | Months | Days | Hours | Min. 7. MARRIED NEVER MARRIED May 28, 1899 WIDOWED [DIVORCED [event 10a. USUAL OCCUPATION (Give kind of work done) 10b. KINO OF BUSINESS OR BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT Give during most of working life, even if retired) News Paper COUNTRY? -West Virginia U.S.A. any 13. FATHER'S NAME MOTHER'S MAIDEN NAME n 24 hours I in Item 18 's Office alt = Joseph H. Dennison Maude Winner and 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unkown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. removal, EXAMINER: This certificate should be executed within the certificate, writing the word "pending" in pencil is should be forwarded to the Chief Medical Examiner's Mrs. Helen Dennison. Abington. Va. 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: Coronary Acclusion INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) ONSET AND DEATH burial-transit cremation, DUE TO Coronary Sclerosis Conditions, If any, which (b) gave rise to immediate DUE TO (a), stating the 7 used as a to burial, underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) WAS AUTOPSY CERTIFICATION PERFORMED? Hypertension YES NO IC should be 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 3 shoul MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. While Not While JIRECTOR: Page its designated a at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection x . Inquiry X. and in my opinion files. FUNERAL DIRECTOR: Undetermined manner death resulted from: Natural causes X Accident Suicide Homicide CHIEF MEDICAL EXAMINER for your ACTUAL SIGNATURE Page 22. DATE SIGNED DEPUTY MED ASSISTANT MEDICAL EXAMINER 1/13/67 0 DEPUTY MEDICAL EXAMINER Benedict Skitarelic Health EXAMINER'S NAME (Type) Address (Street, city, town, or county) Cumberland, Md. director. retained 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, 23b. OATE THEREOF (State) 15/67 Westernport Philos FUNERAL DIRECTOR AOORESS REC'O BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. Westernport, Md. Melarles VR ALSME (5) 1/65

mark in the co 14.000 the same of the same same 1 and the state of t Oranie di Lancie de la Contraction de la Contrac

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00015 00015 death. requires that the death certificate be executed within 24 haurs after death and campletely filled in by the funeral remave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Maryland Allegany Allegany MARYLAND papers. Pages 1 iin 72 hours after b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Cumberland Cumberland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) within 72 406 Virginia Avenue NO P S_cred Heart Hospital Middle 4. DATE Manth 3. NAME OF First Year DECEASED 67 Dentinger Hazel A. DEATH (Type or print) IF UNDER 24 HRS. 9. AGE (In years IF UNDER 1 YEAR 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED mirthdoy) Hours 12/23/11 White Female WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind af wark dane 11. BIRTHPLACE (County & State, or fareign country) 10b. KIND OF BUSINESS OR during most af working life, even if retired) COUNTRY? USA None Allegany Co., Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME the attending physisit permit. Then Hazel Green William Dentinger 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address patient's chart n INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH alunona IMMEDIATE CAUSE (a) signed by DUE TO Canditians, if any, which gave rise to immediate cause (a), DUF TO stating the underlying couse as the the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been **PHYSICIAN:** The law WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) (County) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Not While factory, street, affice bldg., etc.) Haur a.m. at work ot wark 21. I certify that (I) (this haspital) attended the deceased fram_ . 19 . ta . 1967, that (1) (we) last 1-11 be retained 1967, and that death accurred at_ M. fram causes and an the date stated abave. saw the deceased alive an_ 1-11 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR **ATTENDING** STAFF PHYS. allow M.D. PHYS. directar, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S SFIELD 401 NAME (Type) mv LARLTON 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City ar Town) 23b. DATE THEREOF (County) (State) 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Md.Allegany 1967 Jan. 14. Sunset Memorial Park Cumberland, 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE Scarpelli, Cumberland, Md. VR A15 (4) 20 M 1/66 1967

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 00016

| 00016 CERTIFICAT | E OF DEATH 00016 |
|--|---|
| 1. PLACE OF DEATH 2. COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b 31 Yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westernport |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. street address R.D. 1-Westernport o. is residence on a farm? yes \sum no |
| | hong Last 4. DATE Month Day Year DEATH Jan. 10 19 67 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH April 19, 1894 9. AGE (In years IFUNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during more of working life, even if retired) 10b. KIND OF BUSINESS OR OCCUPATION (Give kind of work done during more of working life, even if retired) | 11. BIRTHPLACE (County & State, or foreign country) Somerset Ut. Penna. 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Harvey DeShong | 14. MOTHER'S MAIDEN NAME Martha Allender |
| (Vas no or unknum) ((If you nive way as dates of convice) | INFORMANT Address Ars. Ethel DeShong-Westernport, Md. |
| Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO NO |
| G OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | URRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| Zoc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL/ Hour a.m. While Not While at work at work | ACE OF INJURY (Home, farm, ory, street, office bldg., etc.) (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19, and that | 1961, 19, to, 1967, that (I) (we) last death occurred at 45 M, from the causes and on the date stated above |
| 22a. SIGNATURE William W. Losh M. | |
| 22c. PHYSICTAN'S NAME (Type) William W. Lesh | Westernport, Md. |
| 23a. BURIAL, CRÉMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER BURIAL (Specify) 1/13/67 Philos | Westernport Md. |
| 24. FUNERAL DIRECTOR Westernport, Md. | DATE JAN 13 1967 Jelianles Judge |

VR A15 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH and 2 and 2 death. 24 hours after death. PLACE DF DEATH 1. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY b. COUNTY Maryland and completely filled in by the 1 remove carbon papers. Pages 1 any event, within 72 hours after Allegany MARYLAND b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie Cumberland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Sacred Heart Hospital executed within 3. NAME OF First Middle DATE Month Last DECEASED OF DEATH 1 William DeVore A . (Type or print) 6. CDLOR DR RACE | 7. MARRIED SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 8. DATE OF BIRTH NEVER MARRIED Months | Davs Mal.e White 11/24/879 WIDOWED DIVORCED 三 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND DF BUSINESS OR JINDUSTRY 12. CITIZEN OF WHAT COUNTRY? attending chysician sermit. Then please r 11. BIRTHPLACE (County & State, or foreign country) lelan Railroading death certificate be Ellerslie, Maryland retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John D . De Vore Barbara Witt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yest no, or unkown) (If yes give war or dates of service) has been signed by the atternance as the burial-transit permit, prior to burial, cremation, or 716-10-4175 patient's chart 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] The law requires that the PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (aAcute Myocardial Infarction PHYSICIAN: The law requires that the hospital or attending physician. DUE TO Coronary arteriosclerosis Conditions, If any, which gave rise to immediate DUE TD cause (a), stating underlying cause last. has PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health certificate CERTIFICAT Acute bronchitis; Emphysema; Acute occlusion, rt iliac and L.popliteal YES

20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.)

CITY OF THE PROPERTY OF I be detached for State Dept. of H MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. While Not While After retained by at work at work DIRECTOR: Af age 3 should lied with the S 21. I certify that (1) (this hospital) attended the deceased from January 9, 1967, to January 2019 67, that (1) (we) last 20. 19 67, and that death occurred at 3:10M, from the causes and on the date stated above. saw the deceased alive on Jan. 22b. DATE SIGNED 22a. SIGNATURE 4 may be page filed ATTENDING PHYS. 1-21-67 DIRECTOR M.D. FUNERAL PHYSICHAN'S 22d. ADDRESS director, p NAME (Type) N. Mechanic St. Cumberland Wyand F. Doerner, Jr., M.D. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, DATE THEREOF Bur REMOVAL (Specify) Hyndman, PA, RD#1 JAnuary 24. 1967 Porter Cemetery REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 1967 Hyndman. Pa. DATE

Allegany

Day

20

e. IS RESIDENCE ON A FARM?

Year

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INTERVAL BETWEEN ONSET AND DEATH

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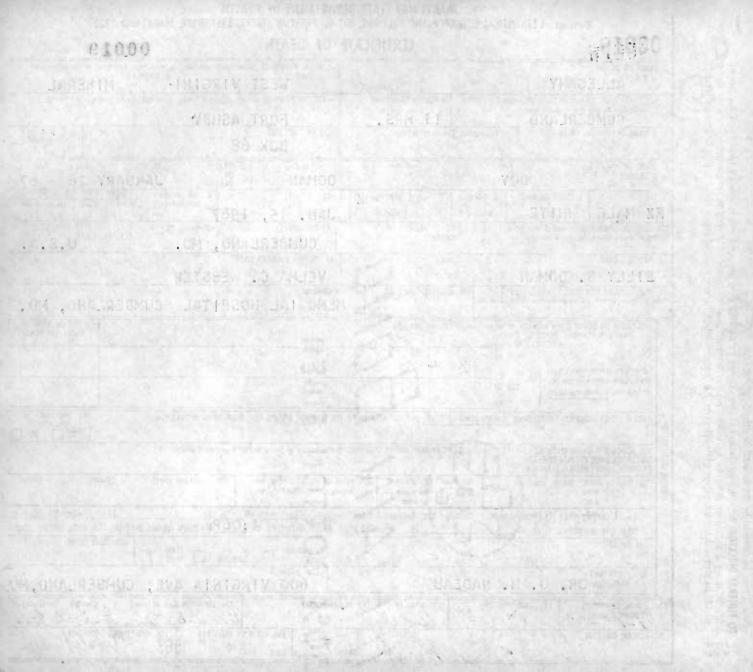
Jinuary 24, 1967 Porter Constany

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00018 by the funeral Pages 1 and 2 aurs after death. executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH ALLEGANY b. COUNTY a. COUNTY a. STATE ALLEGANY MARYL AND MARYLAND and in any event, within 72 haurs after c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) CUMBERLAND DAYS CUMBERLAND e. IS RESIDENCE ON A FARM? papers. d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) campletely filled in MEMORIAL HOSPITAL 704 LOUISIANA AVE. . YES NO X 3 NAME OF Middle 4. DATE Manth Day Year Last First remave carban DECEASED JAN. 20, 1967 DIGGS JOHN W. DEATH (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS. B DATE OF BIRTH 9. AGE (In years S SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** birthday) Manths Days Haurs 4-17-1890 WHITE MALE DIVORCED WIDOWED 12. CITIZEN OF WHAT 10h KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 10a, USUAL OCCUPATION (Give kind of work done pe UCOUNTRY? during mast of warking life, even if retired)
CONDUCTOR INDUSTRY CUMBERLAND. MD. W.M. RAILROAD requires that the death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, ar remaval, phy CATHERINE HAMMERSMITH JOHN H. DIGGS 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yas, na, ar unknawn) (If yes give war ar dates af service) 17. INFORMANT Address 16. SOCIAL SECURITY NO MEMORIAL HOSPITAL - CUMBERLAND. MD. UNKNOWN INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying cause be retained by the haspital or attending of Health priar to far use as the 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? YES NO 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. (County) (State) 20e. PLACE OF INJURY (Hame, farm, (City ar tawn) 20d. INJURY OCCURRED 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Haur a.m. Nat While at wark at wark orgal) attended the deceased fram from 1962 to 20, 1967 that (I) (we) last from Lauses and an the date stated above. 1967 that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram_ shauld O FUNERAL DIRECTOR: saw the deceased glive an-22b. DATE SIGNED 22a. SIGNATURE ATTENDING N directar, page 3 should be filed v M.D. DIRECTOR PHYS ADDRESS 22c. PHYSICIAN'S VIRGINIA AVE., CUMBERLAND, 236 NAME (Type) DURRETT CLAY 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23a BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) CUMBERLAND, MD. ST. PETER & PAUL CEM. BURTAT TAN. 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 CUMBERLAND, MD. BYRON KIGHT

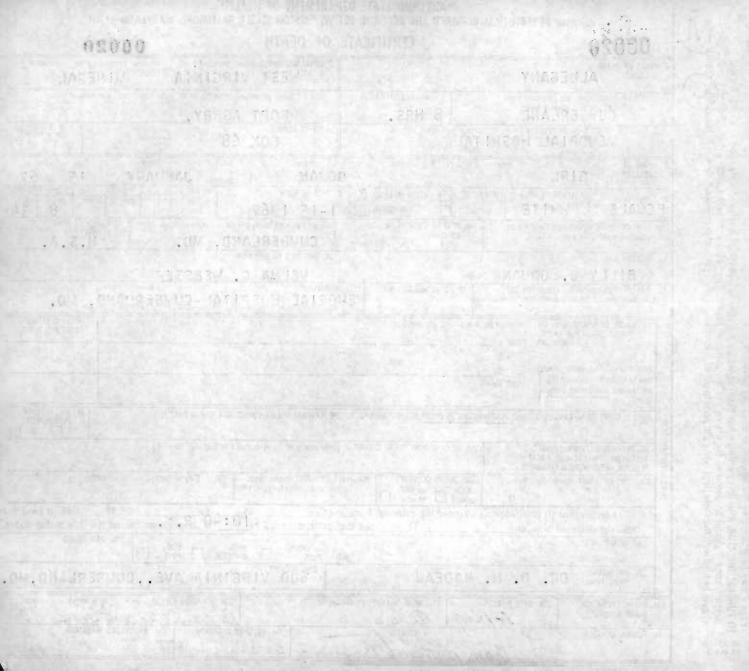
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00019 CERTIFICATE OF DEATH 00019 death certificate be executed within 24 hours after deoth. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) ond completely filled in by the funerol remove carbon popers. Pages 1 ond 1. PLACE OF DEATH O. COUNTY LLEGANY VIRGINIA COUNTY offer MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours HRS. FORT ASHBY CUMBERLAND ve carbon popers. event, within 72 ho IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS BOX 68 NO [3. NAME OF TWIN I Middle 4. DATE First Lost Month Doy Year BOY DOMAN JANUARY 67 16 DEATH (Type or print) AGE (In years lost birthdoy) S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED Hours MALE WHITE and in any WIDOWED DIVORCED 196 JAN. 15. 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY CUMBERLAND. MD. .S.A. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removal BILLY B. DOMAN VELMA C. WEBSTER 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes. no. or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL CUMBERLAND, MD. 70 cremation. 18. CAUSE OF DEATH (Enter only one couse per line for (1), (b), ond (c).) INTERVAL BETWEEN ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY requires thot IMMEDIATE CAUSE (o) p Page 4 may be retained by the hospital or attending physician. DUF TO signed I buriol. Conditions, if ony, which gove (b) rise to immediate couse (o), **DUE TO** stoting the underlying couse os the priar to this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO 0 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH at o (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20d. INJURY OCCURRED (County) 20c. TIME OF INJURY Month, Dov. Yeor Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work O FUNERAL DIRECTOR: After 21. Leertify that (1) (this hospitol) attended the deceased fram 2:04 - 1-15-67, 19 ., 19___, that (I) (we) last director, page 3 should should be filed with the and that death occurred at :06 PM, from causes and on the date stoted above. saw the deceased alive on 22b. DATE SIGNED 220 SIGNATURE STAFF PHYS. ATTENDING DIRECTOR 22d. ADDRESS PHYSICIAN'S NAME (Type) DR NADEAU 0 600 VIRGINIA AVE. CUMBERLAND. MD (Stote) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION REMOVAL (Specify) 1967 REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00020 00020 death. requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission) campletely filled in by the funeral PLACE OF DEATH a. STATWEST VIRGINIA b. COUNTY MINERAL a. COUNTY ALLEGANY MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, and in any event, within 72 haurs HRS. FORT ASHBY. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address)
MEMORIAL HOSPITAL d. STREET ADDRESS ON A FARM? BOX 68 YES NO Twin II Middle 4. DATE Year 3. NAME OF Last Day DECEASED GIRL DOMAN JANUARY 67 19 DEATH (Type ar print) IF UNDER 24 HRS. AGE (In years IF UNDER 1 YEAR 8. DATE OF BIRTH S. SFX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Days FEMALE WHITE -15-1967 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind af wark dane INDUSTRY during most of working life, even if retired) CUMBERLAND. MD. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME BILLY B. DOMAN VELMA C. WEBSTER 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL-CUMBERLAND. MD. (Yes, na, ar unknown) (If yes give war ar dates of service) 70 burial, cremation, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter anly one cause per line for (q), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by DUF TO Canditians, if any, which gave rise ta immediate cause (a) DUE TO stating the underlying cause use as the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CERTIFICATION NO b 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (State) 20f. (City ar tawn) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (Caunty) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Haur a.m at work pe , 19___, that (I) (we) last 21. Lectify that (1) (this haspital) attended the deceased fram : 05/11-1-15 directar, page 3 should should be filed with the sow/the/deceased alive an SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S DR. O. H. NADEAU VIRGINIA AVE.. CUMBERLAND. MD. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION, BEMOVAL (Specify) 23b. DATE THEREOF 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) DATE JAN 1967 20 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) b. COUNTY Allegany o. COUNTY Allegany Maryland Department c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) c. LENGTH OF STAY IN 1b and. Midland Frostburg d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? with the State Dep within 72 hours o alang with farm Item 18. Give Pages 1, Miners Hospital YES NO 3. NAME OF First Middle 4. DATE Lost Year DECEASED 1/28/1967 CHARLES EAGAN (Type or print) 19 DEATH S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours 6/26/1883 White Male WIDOWED X DIVORCED 24 haurs 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Retired Kelly JNDUSTRY COUNTRY? Midland, MD,

14. MOTHER'S MAIDEN NAME e, writing the ward "pending" in pencil in farwarded ta the Chief Medical Examiner 13. FATHER'S NAME be executed within in pencil John Eagan Anna Mc Alister 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no or unknown) (If yes give wor or dotes of service) ar remaval, Midland. Garrett Eagan INTERVAL BETWEEN ONSEL AND DEATH LE Hours 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: Subarachnoid hemorrhage: Cerebral edema IMMEDIATE CAUSE (o) _____ used as a burial-tra This certificate shauld DUF TO Contusions of Brain 4 Hours Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse (Fall at Home Hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? please execute the certificate. Coronary Sclerosis, Marked; Arteriosclerosis generalized YES X NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) PRIMARY or CONTRIBUTING CAUSE OF DEATH Fell at home 20f. (City or town) 20e. PLACE OF INJURY (Home, form, (County) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.)
Home While of work Not While X may be retained far yaur the funeral director. Page 4 19 67 Jan. 28 Midland, Allegany, Maryland 5 may be retained for your TO FUNERAL DIRECTOR: Page Health ar its designated a 21. I certify that I took charge of the remains described above, held an Autapsy Inspection X, Inquiry X, and in my apinian death resulted fram: Suicide . Undetermined manner Natural causes Accident X Hamicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER X January 28, 1967 **EXAMINER'S** BENEDICT SKITARELIC. Address (Street, city, town, or county)Cumberland, Md. NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, Burial (Specify) 1/31/1967 St Michaels Cemetery 250. RECO BY REGISTRAR 255. REGISTRAR'S SIGNATURE O 24. FUNERAL DIRECTOR JAN VR A15ME (5) 6M 1/66 GEORGE EICHHORN Lonaconing, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 00022 2 requires that the death certificate be executed within 24 hours after death ond completely filled in by the funeral remove carbon popers. Pages 1 ond in any event, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY Allegany b. COUNTYAllegany o. STATE Md. MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Yrs. Westernport d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 468 Spruce 468 Spruce NO E YES T NAME OF Middle 4. DATE First Last Manth Dov Year DECEASED Elais Laura Ellen Elias Ban 31 19 67 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 9. AGE (In years 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH NEVER MARRIED last pirthdoy) Months Doys Hours Female White Feb. 24, 1885 X WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? please INDUSTRY physician and Mineral-W. Va. U.S 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME the attending physical period of the part or removol, Tacey Walters Seymour Welsh 17. INFORMANT Elias IS. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) George Elais-Westernport . Md. buriol, cremotion, CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse as the O FUNERAL DIRECTOR: After this certificate hos been 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) and Coremone of Bre NO X for 20a. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Yeor Haur a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) factory, street, affice blda., etc.) Nat While at wark at wark . 1962, to Jan 3/, 1967, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram Jan director, page 3 should should be filed with the Tan. 30 1967, and that death accurred at 12.45 M, from causes and on the date stated above. saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. DIRECTOR M.D. PHYS. TO HOSPITAL (Poge 4 may b 22d. ADDRESS 22c. PHYSICIAN'S Paul R. Wilson Piedmont, W. Va. NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, (County) (State) St. Peters Md. BREMOVAL (Specify) Westernport 2/3/67 25a REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 196 Westernport, Md.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00023 CERTIFICATE OF DEATH executed within 24 hours after deoth affer death and completely filled in by the funeral remove carbon papers. Pages Land in any event, within 72 haurs affer death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY Allegany o. STATE Maryland b. COUNTY Allegany MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) C. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) 1964 Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? 761 Fayette Allegany County Infirmary Street YES NO X 3. NAME OF Middle First 4. DATE Day Year DECEASED 67 Frank Fogtman January (Type or print) 19 S. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED 8 dast birthday) Manths Days Haurs 10/8/1881 White , and in any Male DIVORCED K WIDOWED 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during mast of working life, even if retired)
Retired: Paperhanger INDUSTRY COUNTRY? signed by the ottending physician buriol-transit permit. Then please Maryland requires that the death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Fogtman ar removo Anna Fox 17. INFORMANT P. O. BOX 599. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Addresumberland. Md. 16. SOCIAL SECURITY NO. (Yes, pa_or unknown) (If yes give war ar dates of service Allegany County Infirmary records. buriol, cremotion, CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) Canditians, if any, which gave rise ta immediate cause (a). 4 moy be retained by the hospital or ottending use os the loth of the prior to the stating the underlying cause has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Heolth p TO FUNERAL DIRECTOR: After this certificate YES [NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 3 should be detoched to with the State Dept. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm. (City or town) (County) (State) Haur a.m. Nat While factory, street, affice bldg., etc.) at wark at wark 21. I certify that (I) (this haspital) attended the deceased fram_ 64 ___, that (I) (we) last saw the deceased alive an 1/14/67 and that death occurred at A. M. fram causes and an the date stated above. 4:00 22a. SIGNATURE 22b. DATE SIGNED ATTENDING X DIRECTOR PHYS. director, page should be filed 22c. PHYSICIAN ADDRESS B Mathews. M. Greene St., Cumberland, Md. Lee D. NAME (Type) 23a. BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City as Tawn) (State) MOVAL (Specify) REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE JAN

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120

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| | NAME OF DECEASED (Type or print) | | irst ANNY | Middle M | FOLEY | 4. DATE OF DEATH | Month JAN | Dογ 23 | |
| S. | SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED DIVORCED | 8. DATE OF BIRTH 8-27-86 | 9. AGE (In lost birth | γeors IF hdoy) Mo yrs. | onths Doys I | UNDER 24 HRS. Hours Min. |
| duri | ng most of working Housewi | N (Give kind of work don life, even if retired) f e | | IND OF BUSINESS OR IDUSTRY | W. VA. | nty & Stote, or foreign count | ry) | 12. CITIZEN OF W COUNTRY? | I.S.A. |
| | | NELSON | | | 14. MOTHER'S MAIDE | | | | |
| 15. (Ye | WAS DECEASED EVI es, no, or unknown) No | ER IN U.S. ARMED FORCES (If yes give wor or dote: | ? of service) 16. | | INFORMANT EMORIAL H | OSPITAL | Address CUMB | ERLAND, | MD. |
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| MEDICAL | Hour o. | URY Month, Doy, Yeor m. m. | While | Not While f | LACE OF INJURY (Home, foctory, street, office bldg., | | town) | (County) | (Stote) |
| | | leceased glive an, | | ded the deceased fram. | nat death accurred | 19 ta / h 50P M, fram | | , 19, that d on the date s 22b. DATE SIGNED | (I) (we) la stated abav |
| | 220. SIGNATURE | 4/1/11 | ulle | July 11 | M.D. ATTENDING PHYS. | DIRECTOR PH | YS. 🗆 | 1/25 | 167 |
| | NAME (Type | DR. G.O | VERTON | HYMMELWRIG | HTT133 VA. | AVENUE, | CUMBE | RLAND, | MD. |
| 230 | BURIAL, CREMATI REMOVAL (Specifical) | ON, 23b. DATE 1 Y) 1-26 | | 23c. NAME OF CEMETERY OF Forest G. | len | | en Sp | ring Ham | (Stote) D. W. Va |
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VR A15 (4) 20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages I and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 haurs after depth.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00025 death. within 24 haurs after death 1. PLACE OF DEATH o. COUNTY ALLEGANY 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY o. STATE ALL FGANY MARYI AND MARYLAND or removal, and in any event, within 72 hours after c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b CUMBE RL AND 25 MIN. CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? MEMORIAL HOSPITAL 24 WASHINGTON ST. NO 3. NAME OF First Middle Lost 4. DATE Month Year Dov remove carbon DECEASED JANUARY 15 67 GFARE FI INOR 19 DEATH (Type or print) requires that the death certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED lost Months Doys Hours 12-17-85 WIDOWED X DIVORCED FEMALE physician ond 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY CUMBERLAND. MD. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ROBERT PAUL ROSALIE DEVECMON 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no or unknown) (If yes give wor or dates of service) CUMBERLAND. MD. MEMORIAL HOSPITAL. cremotion, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), buriol-transit PART I. DEATH WAS CAUSED BY signed by IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The low requires the Poge 4 moy be retained by the haspital or ottending physician. DUF TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse this certificate has been os the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use Health YES T NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) be detached State Dept. c 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Dov. Yeor 20d. INJURY OCCURRED Not While foctory, street, office bldg., etc.) Hour o.m. 19 ot work FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased fram. that (I) (we) last director, page 3 should should be filed with the and that death accurred at M. from causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S CUMBERLAND. MD. ORMER NAME (Type) 23o. BURIAL, CREMATION DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 0 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 2Sb. 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00026 CERTIFICATE OF DEATH sician and campletely filled in by the funeral please remave carban papers. Pages 1 and 21, and in any event, within 72 haurs after death. requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY Allegany Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frostburg c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Rural" Frostburg d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Miners Hospital NO TH YES 3. NAME OF Middle 4. DATE Year DECEASED 12 19 67 Florence January Green DEATH (Type or print) 7. MARRIED AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE B. DATE OF BIRTH NEVER MARRIED lost birthdoy) Months Dovs Hours White WIDOWED DIVORCED Female 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? Lonaconing, Maryland
14. MOTHER'S MAIDEN NAME House Wife 13 FATHER'S NAME James Ternent Rachael Darnley 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service permit ar Lindley E. Green Frostburg. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse as the TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use CERTIFICATION NO YES 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached for the Dept. of F (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Yeor foctory, street, office bldg., etc.) Hour o.m. Not While of work ot work 3 should be 21. I certify that (I) (this haspital) attended the deceased fram. . 19. , 19___, that (I) (we) last __ , ta. and that death accurred at_ M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE **ATTENDING** MED. PHYS DIRECTOR directar, page shauld be filed 22d. ADDRESS PHYSICIAN'S NAME (Type) 23/ NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) Burial (Specify) 1967 Sunset Memorial Cumberland Md Park 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 1967 George Eichhorn Lonaconing, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 00027 HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a COUNTY b. COUNTY 2, and 3 to PM3. Page Allegany Allegany Maryland o death. MARYLAND delay ate Department c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b cumber land after days Barton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? rd "pending" in pencil in Item 18. Give Pages 1, Chief Medicol Examiner's Office olong with form hours in Item 18. Give Pages 1, Memorial R.D. #1 YES NO X 24 hours after death. 3. NAME OF First Middle Lost 4. DATE Manth DECEASED 25 January 6 within Green (Type or print) Harry DEATH S. SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 7 MARRIED NEVER MARRIED last birthday) Haurs Feb. 2. 1905 Male White DIVORCED WIDOWED ond 2 event/ 11. BIRTHPLACE (State or foreign country) 10a, USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during reast of warking life, even if retired) Coal Mine COUNTRY ? Maryland Ony 13. FATHER'S NAME John Green 14. MOTHER'S MAIDEN NAME be executed within Alda Broadwater puo 16. SOCIAL SECURITY NO. 17 INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes no ar unknown) (If yes give war or dates af service) or removal, 217-01-7232 Grace Green-Barton, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY Meningitis IMMEDIATE CAUSE (a) This certificate should writing the word buriol, cremation, DUE TO 4 should be forworded to the Canditians, if any, which gove Streptococcal Septicemia rise ta immediate cause (a), DUE TO stating the underlying couse 0 19. WAS AUTOPSY PERFORMED? YES X NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) MEDICAL CERTIFICATION pleose execute the certificote. pe its designated agent, prior to 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) PRIMARY Or CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH. (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (State) factory, street, affice bldg., etc.) Haur a.m. Nat While FUNERAL DIRECTOR: Poge 21. I certify that I taak charge of the remains described above, held an Autapsy XI, Inspection X ond in my opinion Inquiry T for the funerol director. Natural causes (Accident Suicide , Hamicide Undetermined manner death resulted fram: retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIG NATURE TO DEPUTY DEPUTY MEDICAL EXAMINER Heolth or EXAMINER'S January Benedict Skitarelic. M.D. Address (Street, city, tawn, or cauth mberland NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (State) 0 REMOVAL (Specify) 1/28/67 Moscow Mills Md. Laurel Hill ADDRESS 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Westernport, Md.

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| 1 (A) | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR | YLAND |
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| FOR STATE | 00030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | 0 |
| HEALTH DEPT. | 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Resi | dence before admission) |
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| sary, heral y be ment | Allegary b. CITY OR TOWN (if outside corporate limits, write RURAL and write RURAL and give nearest town) Maryland C. CITY OR TOWN (if outside corporate limits, write RURAL are not all the corporate limits. | nd give nearest town) |
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| Der Ste | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| delay . Coessary, nd 3 to the funeral . Page 5 may be state Department hours after death. | Sacred Heart Hospital D.O.A. 632 Fairview Ave. | YES NO D |
| EXAMINER: This certificate should be executed within 24 hours after death. If any delay accessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be riles. Tiles Tole: A should be used as a burial-transit permit. File pages 1 and 2 with the State Department designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. | 3. NAME OF First Middle Last 4. DATE Month OF OF | Day Year |
| PM3. | (Type of print) Sarah J. Haves DEATH Jan. 1 5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1) | TENNER 74 HRS |
| With Mark | last birthday) Months D | ays Hours Min. |
| Page h for | Male White WIDOWED DIVORCED Jan 8 19 8 7 80 yrs. 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITI | IZEN OF WHAT |
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| n 18 | William His Hill. Mary Johnson | |
| 24 hor Hem Office File I | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address | |
| in 2 S C s C it. | (Yes, no, or unknown) (If yes give war or dates of service) Aden L. Hayes 632 Fairview | Ave. |
| within pencil ir miner's miner's permit. | | INTERVAL RETWEEN |
| in p in p it p | PART I. DEATH WAS CAUSED BY: CORONARY Occ/usion | ONSET AND DEATH |
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| d by the creater of t | gave rise to immediate (cause (a), stating the DUE TO | |
| houl ord thief s a | underlying cause last.) (c) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY |
| ficate sho the worn the Chi to burial | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN THE TE | PERFORMED? |
| to the total to the | Hypertensive Cardrovascular dislace 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) | YES NO |
| R. This certificate, writing forwarded to 3 should be agent, prior | Hypertensive Cardovascular disease Contribution of the terminal disease condition d | |
| wr ward ward houl | ZOC. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Countries) | ty) (State) |
| R: T for 3 s | Hour a.m. While Not While factory, street, office bldg., etc.) | |
| EXAMINER the certification of | p.m. 19 at work at work 21. certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , | and in my opinion |
| Cer cer cer cer es. R: P igna | death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner [| |
| the the company of th | CHIEF MEDICAL EXAMINER | 53/40 734 |
| MEDICAL Gecute the Page 4 story your L DIRECT or its d | SIGNATURE Designated Skitarelie M.D. ASSISTANT MEDICAL EXAMINER 1 | 22. DATE SIGNED |
| execute Page i for you the DIRE | DEPUTY MEDICAL EXAMINER | 1761 |
| TO DEPUTY MEDIS EXA please execute the co- director. Page 4 shoul retained for your files. TO FUNERAL DIRECTOR: of Health or its design | EXAMINER'S BENESICT SKITARELIC MAJORES (Street, city, town, or county) Cumber | land, Md |
| D DEPUTY please e director. retained D FUNER of Healtl | 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or countries and 23d. Location (City, town or countr | Md. |
| 2 2 2 0 | Sunset Memo. Park ADDRESS APPRESS REGISTRAR 25b. REGISTRAR'S | SIGNATURE |
| VR ALSME (5) | 1AN 23 1967 Kulan | rles Judge |
| 5M 1/65 | Louis Stein Inc. Cumberland Md. DATE | U |

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Page 4 may be retained by the haspital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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| ges | | CITY OR TOWN (I | f autside carparate limit give nearest town) | s, | c. LENGTH OF STAY | IN 1b | c. CITY OR TOWN (If out | side carparate lim | its, write RUR | RAL and give ne | arest tawn |), |
| by Pa ours | | CUN | BERLAND | | 2 DAY | 1S | CUMBE | RLAND, | MD. | | 01. | |
| in ers. 2 h | - | . NAME OF HOSPITA | AL OR INSTITUTION (If no | at in haspital, gi | ve street address) | | d. STREET ADDRESS | 110117 01 | VENULE | | e. IS R | ESIDENCE A FARM? |
| filled in papers. | | MEMOR | IAL HOSPIT | AL | | | 209 PIED | MONIA | VENUE | | | No X |
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| the Park | 13. | FATHER'S NAME | UENDY | | | 1 10 | 14. MOTHER'S MAIDEN N | | | | | |
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| signed by the attending burial, crematian, ar rem | H | no no | ATII /F-A1 | | .) (1)1(.) | ME | MORIAL HO | SPITAL | CUI | MBERLA | INTERVAL | |
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| this certil detached e Dept. of | MEDICAL | 20c. TIME OF INJU | RY Month, Day, Year 1. | 20d. INJ While | URY OCCURRED Not While | | E OF INJURY (Hame, farm, ry, street, office bldg., etc.) | 20f. (City | ar tawn) | (Caunty |) | (State) |
| ate de | × | p.n | 1. 19 | at work | at work | | | | | | | |
| d be de e State | | 21. I certif | y that (I) (this hos | pital) attend | ed the deceased | fram_ | death accurred as | 000 to | an 18 | 1967 | that (I) |) (we) las |
| S local | | | eceased alive an | four 1 | 1967, | and that | death accurred as | 00A M, 110 | m causes | and an the | | ted abave. |
| DIRECTOR: ge 3 should iled with th | | 22a. SIGNATURE | Dann J | 2 2 | 2/ | M.D | | MED. | STAFF PHYS. | 1 // | 10 | 1919 |
| Die de le | | 22. PHYSICIAN'S | werr) 7 | and Je | | M.U | 22d. ADDRESS | DIRECTOR L | PHIS. | yan | | 1101 |
| RAI be | | NAME (Type) | DR. WYLII | E M. F. | AW JR. | 91 | 122 S. | CENTRE | ST., | CUMBE | RLAN | ND, MD |
| E G B B | 230 | BURIAL, CREMATIC | N. 23b. DATE THE | EREOF | 23c. NAME OF CEM | ETERY OR C | REMATORY | 23d. LOCATIO | N (City or Tox | wn) (Co | unty) | (Stote) |
| TO FUNERAL DIRECTOR: After this cedirector, page 3 should be detached should be filed with the State Dept. | | BEMOVAL级理city | | | | | orial Park | | , , | Md.Al | ,, | nv |
| = | 24 | FUNERAL DIRECTO | 8 0 | a .: | ADDRESS | | | BY REGISTRAR | 2Sb. RE | GISTRAR'S SIGN | ATURE | |
| VR A15 (4) 20 M 1/66 | | James 1 | . Scarpel. | 11, Cun | berland, | Md. | DATE JA | N 2 4 19 | 367 h | Maril | es Ju | dakon |

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| (M) | | DIVISION OF STATISTICAL RESE | ARCH AND RECORDS | | N STREET, BALTIM | |
|--------------|---------------|--|---|--------------------------|------------------------------------|---|
| and 2 death. | | 00032 | CERTIFICATI | E OF DEATH | 1 | 00032 |
| | 1. | PLACE OF CEATH a. COUNTY | | 2. USUAL RESIDEN | CE (Where deceased lived, If i | nstitution: Residence before admission) |
| | | ALLEGANY | MARYLAND | MA | RYLAND | ALLEGANM |
| | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (II | outside corporate limits, v | vrite RURAL and give nearest town) |
| | | CUMBERLAND | | CUMBERI | AND | 01.1 |
| | | d. NAME OF HOSPITAL OR INSTITUTION (if not in i | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? |
| 9 | - | SACRED H EART HOSP | | 310 PIEDM | | YES NO X |
| V | | NAME OF First OECEASEO | Middle | Last | 4. OATE Mon | |
| A | 5. | (Type or print) SEX G. COLOR OR RACE 7 MARRIED | | ERSH B. DATE OF BIRTH | 9. ACE (In years | NUARY 23 19 67 |
| 1 | | Windows | THE | 10/16/06 | last birthday | Months Days Hours Min. |
| 1 | 10a. | USUAL OCCUPATION (Give kind of work done 10h. | KIND OF BUSINESS OR | | ounty & State, or foreign count | ry) 12. CITIZEN OF WHAT |
| L | | ng most of working life, even if retired) Ga | INDUSTRY S CO. | Penna | . Meyers dale | U. S. A. |
| ľ | 13. | motion work (Sales) da | | 14. MOTHER'S MAIL | DEN NAME | |
| 1 | | Adam Hersh (decea | sed) | Mart | ha Sipple (D | eceased) |
| | 15. (Yes | WAS OECEASEO EVER IN U.S. ARMED FORCES? 16, no, or unkown) (If yes give war or dates of service) | | INFORMANT | Addr | |
| | | yes. W. W. # 2 | 282-09-9816 Mrs | . Agnes Her | sh 310 Piedmor | it Ave. Cumb. Md. |
| | | 18. CAUSE OF DEATH [Enter only one cause per | | 0 | | INTERVAL BETWEEN ONSET AND CEATH |
| П | | PART I. DEATH WAS CAUSED BY: | ente course | 4, Occh | was B | 3 days |
| | | 420:/ OUE TO | | , | | 6 11 |
| | | gave rise to immediate (b) | ornery ou | um | | Munor |
| | | cause (a), stating the DUE TO underlying cause last. | | | | |
| | No | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB | UTING TO DEATH BUT NOT RELA | TED TO THE TERMINAL | DISEASE CONDITION CIVEN I | N PART 1(a) 19. WAS AUTOPSY |
| | CAT | | | | | PERFORMED? |
| | CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING 1 20b. | DESCRIBE HOW INJURY OCCU | RRED. (Enter nature o | f injury in Part I or Part II | of Item 1B.) |
| - 1 | | OR CONTRIBUTING CAUSE OF OF ATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| | MEDICAL | | facto | CE OF INJURY (Home, f. | arm, 20f. (City or town) | (County) (State) |
| | MED | p.m. 19 at wo | Not while | | | |
| | | 21. I certify that (I) (this hospital) attended | | /- 8 - , 1 | 967, to 1-23 | |
| | | saw the deceased alive on | 19 6, and that | death occurred at_ | M, from the cause | s and on the date stated above. 1 22b. DATE SIGNEO |
| | | ZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZ | / | | MEO. STAFF | 1 1-25-67 |
| | | 22c. PHYSICIAN'S | M.D | PHYS. 22d. AOORESS | DIRECTOR PHYS. | |
| | | NAME Dr. L. Brings | | | ene St., Vumbe | |
| | 23a. | REMOVAL (Specify) | 23c. NAME OF CEMETERY | | 23d. LOCATION (City, | |
| | 24 | Burial 1/26/67 FUNERAL DIRECTOR | Hillcrest Bu | rial Park | Cwnberland C'O BY RECISTRAR 256. | REGISTRAR'S SIGNATURE |
| | 24. | | rland, Maryland | | AN 27 1967 | Minter Judge |
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00033 CERTIFICATE OF DEATH death. 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) filled in by the funeral papers. Pages 1 and PLACE OF DEATH ALLEGANY o. COUNTY o. STATE b. COUNTY Mercykand Maryland Allegany hoors after MARYLAND PHYSICIAN: The low requires that the death certificate be executed within 24 hours after b. CITY OR TDWN (If outside carporate limits, c. LENGTH DF STAY IN 16 c. CITY DR TDWN (If outside corparote limits, write RURAL and give nearest town) write RURAL ond give nearest town) Cumberland Cumberland years e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 Arch Street 221 Arch Street YES NO TO g physician ond completely fi NAME OF First DATE Lost Doy Year DECEASED OF. 11 67 Jan. Frank Edward Hiles DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years 7. MARRIED birthdoy) Months Doys Hours Male White 12.26.67/ 1894 DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 1Do. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)

Retired Ice House Employee-Railroad USA FULTON COUNTY PENNA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME EDWARD HILES ALMEDA SPEILMAN 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no or unknown) (If yes give war or dates of service 5 JOSEPH HILES HANCOCK MD. cremotion, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I. DEATH WAS CAUSED BY: burial-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (o) signed by Poge 4 moy be retained by the hospital or ottending physicion. DUF TO Conditions, if any, which gove (b) rise to immediate couse (o), DHE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? CERTIFICATION Heolth YES [NO for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 19 6 6, to your 21. I certify that (I) (this haspital) attended the deceased fram_ 19 6 /, that (I) (we) last should saw the deceased alive an. and that death accurred at M. fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING X Jan.12,1967 DIRECTOR M.D. PHYS director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 236 Virginia Ave., Cumberland, Md. Clay E. Durrett, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (State) 23o. BURIAL, CREMATION, (County) .14.67 REMOVARISPECTY) PRESBYTERIAN WASHINGTON HANGOCK 2Sb. REGISTRAR'S SIGNATURE ADDRESS 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Ochanila.

MARYLAND STATE DEPARTMENT OF HEALTH

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00034 CERTIFICATE OF DEATH death. certificate be executed within 24 haurs after death and campletely filled in by the funeral remave carban papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY o. COUNTY o. STATE ALLEGANY MARYLAND MARYLAND 72 hours after c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, DAYS FROSTBURG e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? MINERS HOSPITAL NO T COLLEGE Middle DATE 3. NAME OF First Month Year DECEASED OF DEATH WILLIAM M. JAMES (Type or print) AGE (In yeors 'IF UNDER IF LINDER 24 HRS 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED Y NEVER MARRIED lost birthdoy) Months Hours MALE WIDOWED DIVORCED NOV. 25, 1900 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) LONACONING. MARYLAND 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME SAMUEL JAMES JESSIE MCMILLAN 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. FRUSTBURG. MD. requires that the death (Yes, no or unknown) (If yes give wor or dotes of service) 213-07-7850 MRS. WILLIAM JAMES INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH burial-transit IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES X NO far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED Not While factory, street, office bldg., etc.) ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram daw - 4 saw the deceased alive an JAN. 7 1967, and that death accurred at 5.25 PM, fram causes and an the date stated above 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S EAST NAME (Type) STRONG, MD. PAIGE STREET FROSTBURG 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) 23o. BURIAL, CREMATION, JAN.10.1967 HILLCREST BURIAL PARK CHMBERLAND REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE FUNERALDHOME. 60 W. MAIN 1967 DATE FROSTBURG.

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00035 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 00035 HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 2, and 3 to PM3. Page g. COUNTY o. STATE h COUNTY ALLEGANY MARYLAND MARYLAND ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YRS CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Item 18. Give Pages 1, Office alang with farm haurs MEMORIAL HOSPITAL 1108 HOLLAND STREET YES NO IZ after death. 3. NAME OF 4 DATE Lost Day Month Year within 72 DECEASED RAYMOND (Type or print) ROBERT JOHNSTON JAN. 19 67 DEATH S. SEX 9. AGE (In years last birthdoy) 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Months Dovs Hours WIDOWED DIVORCED event MALE WHITE APRIL 29, 1891 1Do. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

Retired Police Lt.

13. FATHER'S NAME INDUSTRY COUNTRY? 24 City Police Cumberland

14. MOTHER'S MAIDEN NAME II. S. A be executed within pencil .⊑ MARY JOHNSTON
17. INFORMANT NATHAN JOHNSTON and WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1315 Bedford Street remaval (Yes, no, or unknown) (If yes give wor or dotes of service) YES 220-40-1358 RICHARD N. JOHNSTON Cumberland, Md. W.W.] 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), INTERVAL BETWEEN Davs PART I. DEATH WAS CAUSED BY Pulmonary Emboli, Bilateral ы IMMEDIATE CAUSE (o) This certificate shauld burial, cremation, DUE TO 11 Cardiac Fibrillation Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse Ischemia. Coronary Disease last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? certificate, Marked anemia YES X NO Health or its designated agent, prior ta 2Do. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Part II of item 1B.) PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH 2Dc. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While factory, street, office bldg., etc.) may be retained for yaur FUNERAL DIRECTOR: Page of work please execute ot work 21. I certify that I took charge of the remains described above, held on Autapsy X. Inspection X Inquiry X and in my apinian Notural causes . Accident . death resulted from: Suicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY DEPUTY MEDICAL EXAMINER January 2, 1966 **EXAMINER'S** BENEDICT SKITARELIC, M.D. Address (Street, city, town, or commberland, Maryland NAME (Type) 23o. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) 0 BURTAL (Specify) Jan. 5. 1967 ROSEHILL CEMETERY CUMBERLAND, Md. 2Sb. REGISTRAR'S SIGNATURE 404 Decatur Street 2So. REC'D BY REGISTRAR ocharles VR A15ME (5) JAN 3 1967 SILCOX FUNERAL SERVICE Cumberland, Md.

the instance of the second of X June 2, 1945 A WANTED SHEET, ... Electronic, Francisco a made section and the section of th

MARYLAND STATE DEPARTMENT OF HEALTH ... Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00036 CERTIFICATE OF DEATH 00036 requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) filled in by the funero papers. Pages 1 and a. COUNTY ALLEGANY b. COUNTY n any event, within 72 hours after MARYLAND ALL FGANY b. CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write Rucks and give regards town) 10 HRS. CUMBERLAND e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS MEMORIAL HOSPITAL 115 LAING AVENUE YES NO 2 3. NAME OF remove corbon First Middle Last 4. DATE Month Year DECEASED ANNA JANUARY 1967 MAF Type or print) KEISTER DEATH 9. AGE (In years IF LINDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED 64 bighday) Haurs FEMALE WHITE WIDOWED SE DIVORCED attending physician and permit. Then please rem 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar fareign cauntry) during most of working life, even if retired) INDUSTRY COUNTRYS Own Home ECKHART. MARYLAND A. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal. LEWIS. ABRAHAM MARTHA WILLISON 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO CUMBERLAND. MD. permit. (Yes, no, or unknown) (If yes give war or dotes of service MEMORIAL HOSPITAL. no burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Myocardeal whatever acert, hospering signed by t IMMEDIATE CAUSE (a) 4 may be retained by the haspital or attending physician. DUE TO Canditians, if ony, which gove (b) rise to immediate cause (o), DUE TO ficate has been s for use as the t f Health priar to b stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS' PERFORMED? NO this certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Port II af item 18.) OR CONTRIBUTING [T] CAUSE OF DEATH Stote Dept. of directar, page 3 should be detoched should be filed with the Stote Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor Haur a.m. foctory, street, affice bldg., etc.) Nat While ot wark ot work O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased fram april 196 / that (I) (we) last saw the deceased olive on the 28 196/, and that death occurred at M. from tauses and on the date stated above. 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. **ATTENDING** 2-1=e6 DIRECTOR PHYS. 22d. ADDRÉSS 22c. PHYSICIAN'S NAME (Type) DR. CUMBERLAND, MD. G. WEISMAN 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23b. DATE THEREOF (State) 23a. BURIAL, CREMATION, (Caunty) BREMOYAL (Specify) Jan.31.1967 Eckhart Cemetery Eckhart, Md. Allegany 25b REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR Scarpelli, Cumberland, Md. harles VR A15 (4) 20 M 1/66 1967 DATEB

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE Item #9 Film # OF DEATH 00032 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. death. and campletely filled in by the funeral remove carbon papers. Pages 1 and in any event, within 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY ALLEGANY MARYI AND ALLEGANY MARYIAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b 24 DAYS CUMBERLAND, MD. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ent, within 72 432 COLUMBIA ST. YES NO X Memorial Hospital 3. NAME OF First Lost 4. DATE Month Doy Year DECEASED TINA KENNEDY JAN 19 67 (Type or print) DEATH S SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED ost birthdoy) Hours WHITE FEMALE 2-25-95 crematian, ar removal, and in any WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTRY? INDUSTRY TEXAS -BROWNWOOD U.S.A. none 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME OSCAR COLLY BONNIE CAIN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dates of service) 220-46-9069 MEMORIAL HOSPITAL CUMBERLAND, MD. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit 20NSET AND DEATH PART I. DEATH WAS CAUSED BY: Cerebral Edema IMMEDIATE CAUSE (o). signed by Page 4 may be retained by the haspital ar attending physician. DUE TO burial. Stroke with right hemiplegia, acute 24 days Conditions, if ony, which gove rise to immediate couse (o), on 12-30-66 DUE TO far use as the b f Health priar tab stoting the underlying couse FUNERAL DIRECTOR: After this certificate has been (a) Hypertensive and arteriosclerotic CVD vears WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) of Health heart failure: cellulitis 1. leg: pneumonitis YES 🗍 NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) State Dept. (City or town) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) foctory, street, office bldg., etc.) Hour a.m. Not While 19 at work 3 shauld be 21. I certify that (I) (this hospital) attended the deceased from Dec. 30, 19 66, to January, 25, that (I) (we) last sow the deceased alive on Jan. 23, 1967, and that death occurred of 35AM, from causes and on the date stated above. director, page 3 shauld shauld be filed with the 22o. SIGNATURE. 22b. DATE SIGNED ATTENDING STAFF PHYS. X 1-26-67 M.D. DIRECTOR 22d. ADDRESS 414 N. MECHANIC ST., CUMB. DOERNER JR. MD. 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Jan. 25, 1967 St. Mary's Cemetery Cumberland, Md. Allegany 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Scarpelli, Cumberland, Md. Charles VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIWISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after death and PLACE OF DEATH a. CDUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. CDUNTY by the fi Pages 1 urs after Allegany Allegany Marvland MARYLAND b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENCTH DF STAY IN 1b c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Cumberland Ξ d. NAME DF HDSPITAL DR INSTITUTION (if not in hospital, give street address) in any event, within 72 h filled d. STREET ADDRESS e. IS RESIDENCE DN A FARM? Sacred Heart Hospital Washington St. 407 YES | ND X DOA within completely NAME DE Middle Last DATE Day Year DECEASED 19 67 C. Lancaster 10 (Type or print) Janet DEATH 5 SFX DATE DF BIRTH 6. CDLDR DR RACE ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthday) | Months | Days Hours | 5/21/04 and Female White WIDDWED X DIVORCED [yrs. 10a. USUAL DCCUPATION (Give kind of work done | 1Db. KIND DF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT been signed by the attending physician the burial-transit permit. Their please in to burial, cremation, or removal, and in INDUSTRY CO. pe during most of working life, even if retired) CDUNTRY? Court House secretary Alleg. Co. Maryland S certificate 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME Robert McMurdo Margaret Askev 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SDCIAL SECURITY ND. 17. INFDRMANT death (Yes, no, or unkown) | (If yes give war or dates of service) 220-16-5920 Mrs. Sara Rank Tilghman St. Cumberland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. Mamou IMMEDIATE CAUSE (a) DUE TD Conditions, If any, which gave rise to immediate DUF TD cause (a), stating the as th underlying cause last. CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY 19. for use Health use PERFORMED? certificate the hospital or YES I ND [PHYSICIAN: 2Da. ACCIDENT WAS UNDERLYINC ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HDW INJURY DCCURRED, (Enter nature of Injury In Part I or Part II of Item 18.) tached f MEDICAL 20c. TIME DF INJURY Month, Day, Year 20d. INJURY DCCURRED | 20e. PLACE DF INJURY (Home, farm, 2Df. (City or town) (County) (State) det factory, street, office bldg., etc.) Hour a.m. Not While After be retained by at work at work O 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should iled with the and that death occurred at 7 P.M., from the causes and on the date stated above. 1-92 saw the deceased alive on. 22a. SIGNATURE 22b. DATE SICNED page ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) N. Smallwood St. NAME OF CEMETERY DR CREMATORY 23d. LDCATIDN (City, town or county) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREDE 23c. REMDVAL (Specify) Alleg Md. Burial Cumberland 796 Cemetery ADDRESS REC'D BY RECISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25a. 6umberland A lto VR AI5 (4) Avie 2DM 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00040 00040 CERTIFICATE OF DEATH death. be executed within 24 haurs after death by the funeral Pages 1 and 2 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY ALLEGANY o. STATE b. COUNTY and in any event, within 72 haurs after MARYLAND MARYLAND ALLEGANY b. CITY OR LOWN (If autside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) 24 DAYS CUMBERLAND CUMBERLAND and completely filled in remave carban papers. d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 522 LOUISIANA AVE. MEMORIAL HOSPITAL YES 🗍 NO KX NAME OF Middle First 4. DATE Lost Month Year DECEASED LAUER 18 1967 JANUARY OTTO M. (Type or print) DEATH 1 YEAR S. SEX AGE (In years IF UNDER IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH **NEVER MARRIED** lost birthday) Months Dovs Hours MALE WHITE 0-9-91 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) COUNTRY? INDUSTRY attending physician permit. Then please NEW YORK. NEW YORK MAINTANENCE MAN requires that the death certificate HOTET, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, UNKNOWN LAUER UNKNOWN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address permit. (Yes, no, or unknown) (If yes give war or dates of service) MEMORIAL HOSPITAL. CUMBERLAND, MD. 111 09 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gove rise ta immediate cause (o). DUE TO stating the underlying couse FUNERAL DIRECTOR: After this certificate has been irector. Dage 3 should be detached far use as the detached far use as the te Dept. of Health priarta lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II af item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page 3 shauld be detache shauld be filed with the State Dept. 20c. TIME OF INJURY Manth, Doy, Year 20e. PLACE OF INJURY (Home, farm, (City or town) 20d. INJURY OCCURRED (County) (State) Hour a.m. factory, street, affice blda., etc.) Not While 19 at work at wark :25 tap www 21. I certify that (I) (this hospital) attended the deceased fram and that depth accurred at M, fram causes and on the dote stated abave. saw the deceased glive on June 22o. SIGNATURE 22b. BATE SIGNED STAFF PHYS. M.D. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S SCHINDLER CUMBERLAND. MD. NAME (Type) DR. BLANE 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) CUMBERLAND, MD. JAN. 21,1967 2 SUNSET MEMORIAL PARK 24. FUNERAL DIRECTOR BYRON **ADDRESS** REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE KIGHT CUMBERLAND. MD. VR A15 (4) 20 M 1/66

ME INC. NO. NOSPITALE. est your, hell your left. I. S. S. stancea measuring deeps and a second in the second of the second of

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| | 3. FATHER'S NAI | | | | 14. MOT | HER'S MAIL | EN NAME | | | | | |
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| - | 15. WAS DECEASED | EVER IN U.S. ARMED FDI | RCES? 16. | 0 | . INFORMAN | T | | Addre | ess | | | |
| ' | ies, no, or unkown) | (11 yes give war or dates or | | 03-4024 | patie | ent's | chart | | | | | |
| = | 18. CAUSE OF | DEATH [Enter only one | cause per | line for (a), (b), and (c).] | - | | | | | INTE | RVAL BE | TWEE |
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| | gave rise to cause (a), | | то | | | | | | | | | |
| 41 | underlying cau | ise last. | (c) | | | | | | | | | |
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| CIL | | + DFARCT | | | SIZNO | Color Contract | | LON | | YE | s 🗌 | NO |
| ï | OR CONTRIBUT | T WAS UNDERLYING TING CAUSE OF DEAT OTIFY MEDICAL EXAMIN | H 2Db. | DESCRIBE HOW INJURY OCC | CURRED. (Ent | er nature of | injury in P | ert I or Part II | of Item 18. |) | | |
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MARYLAND STATE DEPARTMENT OF HEALTH
División of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | | 00042 | | | CERTIFICATE | OF DEATH | | 0004 | 2 |
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| | | LACE OF DEATH | | | MADMANO | a. STATE | here deceased lived, if instit b. CO | | efore odmissian) egany |
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| | | emale | White | WIDOWED | | Feb. 5, 188 | 113. | | |
| | 10o. | USUAL OCCUPATION | (Give kind of wark done | 10b. KI | ND OF BUSINESS OR DUSTRY | | & State, ar foreign cauntry) | 12. CITIZEN COUNTR | 177 |
| | uom | none | life, even if retired) | | none | Cumberlar | | | USA |
| | 13. | FATHER'S NAME | Mark Aller | | | 14. MOTHER'S MAIDEN N | AME | | |
| | | John | D. Lippo | ld | his contraint | Anna Ma | lone | | Section 1 |
| 1 | 15. | WAS DECEASED EVI | R IN U.S. ARMED FORCES? (If yes give war or dotes o | 16. | | NFORMANT | | dress | |
| | (16 | no, or diknown) | (ir yes give war or do les o | 21 | 8-48-9024 Mr | s. Mary L. | Owens, Cumb | erland, | Md-Sister |
| | | 1B. CAUSE OF D | EATH (Enter only one cau | | (o), (b), and (c).) | | | | INTERVAL BETWEEN |
| | | PART I. DEA | TH WAS CAUSED BY: IMMEDIATE CAUSE | (a) | Maeme | a | | | ONSET AND DEATH |
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| | | last. |) | (c) /2 | acture 1 | · Hory | | • | 6 days |
| 1 | 2 | PART II. OTHER S | GNIFICANT CONDITIONS C | ONTRIBUTING T | O DEATH BUT NOT RELATED TO THE | HE TERMINAL DISEASE CON | DITION GIVEN IN PART 1(o) | | 19. WAS AUTOPSY PERFORMED? |
| | ATIO | | | | | | | | YES NO |
| | | 20a. ACCIDENT WA | S UNDERLYING | | SCRIBE HOW INJURY OCCURRED. (| Enter noture of injury in F | Part I or Part II of item 18.) | | |
| | 8 | (IF EITHER, NOTIFY | CAUSE OF DEATH MEDICAL EXAMINER) | Fe | el m Batt | non | | | |
| 1 | MEDICAL CERTIFICATION | 20c. TIME OF INJ | URY Manth, Doy, Yeor | | | E OF INJURY (Hame, form | | | (State) |
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| | | | | | ded the deceased fram | June 1965T | 9 to John | 1960% | that (I) (we) las |
| | | saw the d | eceased alive an | Aten.1 | 6 1967, and that | death accurred at | M, fram cause | s and an the c | date stated abave |
| | | 22a. SIGNATURE | 1 2 | / | | A SHOULD SHOW | | 22b. DATES | IGNED |
| 3 | | | Clay. | 1 | surrett M.D | ATTENDING PHYS. | MED. STAFF DIRECTOR PHYS. | 0 1/19 | 9/67 |
| , | | 22c. PHYSICIAN'S | | | | 22d. ADDRESS | | | · / |
| | | NAME (Type | Dr. Clay | E. Du | rrett, M.D. | 236 Vir | ginia Ave., | Cumberla | and, Md. |
| | 23a | BURIAL, CREMATI | ON, 23b. DATE THI | EREOF | 23c. NAME OF CEMETERY OR C | REMATORY | 23d. LOCATION (City or | Town) (Cou | unty) (Stote) |
| 1 | | Burial Specific | Jan.2 | 1,1967 | SS.Peter & | Paul Cemete | ery Cumberl | and Ma. | Allegany |
| 1 | 24 | FUNERAL DIRECTO | OR . | | ADDRESS | 2So. REC'D | BY REGISTRAR 2Sb. | REGISTRAR'S SIGNA | ATURE |
| 0 | | James F. | Scar pelli | . Cum | perland, Md. | DATE 16 | IN 2 U 1967 | (Cleaner) | a Ouser |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00043

| | a. COUNTY | | | | | 2. USUAL RESIDE | | b. COUN | | teter petote | |
|-----------------------|--|--|--|---|---|--|--|---|--|---|--|
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| | write RURAL | N (if outside corpora and give nearest tov | ite limits, wn) | c. LENGTH OF ST | TAY IN 1b | c. CITY OR TOWN (| | orate limits, wri | te RURAL an | d give neare | est town) |
| _ | CUMBERL | | | | | CUMBER | | | | 01.1 | |
| | d. NAME OF HOS | PITAL OR INSTITUTION | ON (if not in ho | ospital, give stree | it address) | d. STREET ADDRES | S | | | e. IS RE | SIDENCE FARM? |
| | SACR | ED HEART HO | SPITAL | | | 210 GRI | EENE ST | | 3.53 | YES 🗌 | NO X |
| 3. | NAME OF DECEASED | F | Irst | Middle | | Last | 4. DATE | Month | | Day Ye | ear |
| _ | (Type or print) | WILLI | | Joseph | | GSDON | DEATH | JANUARY | 7 2 | 3 19 | 67 |
| 5. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARR | IED 🔲 8 | B. DATE OF BIRTH | | AGE (In years last birthday) | | EAR IF UNDE | |
| | ALE | WHITE | MIDOMED | DIVOR | CED 🔲] | NOV. 27,190 | 00 | 66 yrs. | | ys Hours | 14/111. |
| 10a dur | a. USUAL OCCUPAT | ION (Give kind of working life, even if retire | done 10b. Ki | IND OF BUSINESS | | 11. BIRTHPLACE (| (County & State, o | r foreign country |) 12. CITIZ | ZEN OF WHA | \T |
| | Machini | st | B. | & O. Rwy. | | LONACONI | ING. MAR | YLAND | U.S. | | |
| 13. | . FATHER'S NAM | E | | | | 14. MOTHER'S MA | IDEN NAME | | | | |
| | STANL | EY LOGSDON | (D) | | | X DO THE SOUR | MARG | ARET HEL | MSTTTT | EB | |
| 15 (Ye | . WAS DECEASED E | VER IN U.S. ARMED FO (If yes give war or dates of | DRCES? 16. | SOCIAL SECURITY | NO. 17. | INFORMANT | | on 210 (| | | umb. |
| | No. | | | 5-05-5304 | 1 1 | T'S CHART | . Logs a | 011 210 | neene | 3.6. (| Md. |
| | 18. CAUSE OF | DEATH [Enter only on | ne cause per li | ne for (a), (b), and | i (c).] | | | | 1 | NTERVAL BI | ETWEEN |
| | PART I. DE | ATH WAS CAUSED BY IMMEDIATE CAUSE | (a) Acute | Abdemen | e per | ritonitis | | | | 2 day | |
| | 4201 | DUE | TO | | | | | | | | |
| 1 | Canditions If | | MAGAI | atamia th | man had | nd or | | | | | |
| | Conditions, if | | (p) 110961 | ateric th | T.OHID OF | 3 T'S: | | | | | |
| | gave rise to | Immediate (| (D) | HUGITE UN | T.ONIDO: | 3 T'S: | | | | | |
| | | Immediate ating the DUE | TO ACVD | aceric ch | T-ONIDO: | | | | | 6 year | r s ; |
| rion | gave rise to cause (a), st underlying caus | Immediate ating the last. | TO ACVD | | | TED TO THE TERMINAL | L DISEASE CONDI | ITION GIVEN IN F | PART1(a) | 19. WAS A | UTOPSY |
| ICATION | gave rise to cause (a), st underlying caus | Immediate ating the last. | (c) ACVD | TING TO DEATH BU | JT NOT RELA | TED TO THE TERMINAL | L DISEASE CONDI | ITION GIVEN IN F | PART1(a) | 19. WAS A | |
| TIFICATION | gave rise to cause (a), st underlying caus PART II. OTHER S History 20a. ACCIDENT | Immediate ating the e last. IGNIFICANT CONDITION OF TWO CV | (c) ACVD ONS CONTRIBU | TINGTO DEATH BU | ITNOTRELA | TED TO THE TERMINAL | | | | 19. WAS A PERFO | UTOPSY RMED? |
| CERTIFICATION | gave rise to cause (a), st underlying caus PART II. OTHER S History 20a. ACCIDENT | Immediate ating the last. IGNIFICANT CONDITION Of two CVA | (c) ACVD ONS CONTRIBU | TINGTO DEATH BU | ITNOTRELA | TED TO THE TERMINAI | | | | 19. WAS A PERFO | UTOPSY RMED? |
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| MEDICAL | gave rise to cause (a), st underlying caus PART II. OTHERS History 20a. ACCIDENT OR CONTRIBUTI (IF EITHER, NOT 20. TIME OF I Hour a.n.p.n. 21. I certify saw the dec 22a. SIGNATUR 22c. PHYSICIA NAME (Ty | Immediate ating the least. IGNIFICANT CONDITION Of two CVI WAS UNDERLYING NAUSE OF DEA TIFY MEDICAL EXAMI NJURY Month, Day, 1. 19 y that (I) (this hos) teased alive on The least of the least | (c) ACVD ONS CONTRIBU A's and TH 20b. D While at work pital) attende 1 \$\to 23 Ballin | TINGTO DEATH BU TWO COPO ESCRIBE HOW IN HJURY OCCURRED Not While at work 19 67 | DINOTRELA PARTY LUURY OCCU 20e. PLAI factor factor if from and that M.D | CE OF INJURY (Home, ry, street, office bldg., death occurred at ATTENDING PHYS. | of injury in Pariform, 20f. (C. 1959, to M., from MED. DIRECTOR Cumberl. | it or Part II of Ity or town) 23 n the causes a STAFF PHYS. | (County , 1967 and on the 22b. DATE | 19. WAS A PERFO YES , that (I) (date state SIGNED | UTOPSY RMED? NO (State) (State) (we) last d above. |
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Teleb W. Bellin, M. . 62 Greene St. Cunberland, M. 21502

FOR STATE HEALTH DEPT.

O DEPUTY MEDIAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is cessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. along with form PM3. Page 5 may be TO FUNERAL DIRECTOR: Page 3 should be used as a burlal-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. retained for your files. TO DEPUTY MEDIC

> VR AI 5ME (5) 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL FYAMINED'S CEDITION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| - | | |
|---------------|--|--|
| 1. | PLACE OF DEATH a. COUNTY Allegany MARYLAN | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY Allegany |
| | b. CITY OR TOWN (If outside corporata limits, writa RURAL and give nearast town) | |
| 1 | Cumberland. | Rt. # 2 Cumberland. 11.1 |
| - | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addr | d STREET ADDRESS |
| | D. O. A. Sacred Heart Hosp. | Balto. Pike, 6 mi. E. 06 VES □ NO 🖾 |
| 3. | NAME OF First Middle DECEASED | Last 4. DATE Month Day Year |
| | (Type or print) Franklin Levi | May DEATH January 20, 1967 |
| 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. last birthday) Months Days Hours Min. |
| | Male White WIDOWED DIVORCED T | April 2, 1917 49 yrs. Months Days Hours Min. |
| 10 | a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT |
| dui | ring most of working life, even if retired) INDUSTRY | COUNTRY? |
| 12 | Mechanic Automobile FATHER'S NAME | Flintstone, Maryland U.S.A. |
| 13 | . FATHER S NAME | |
| | Edward May | Nina Teeter |
| 15 (Y | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. es, no, or unknown) (If yes give war or dates of service) | 17. INFORMANT Address |
| 1. | No. | Mrs. Catherine May Rt. # 2 Cumberland, Md. |
| - | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | I INTERVAL BETWEEN |
| | PART 1. DEATH WAS CAUSED BY: Frontuned shull | crushed chest: multiple fractures Sudden |
| 1 | V179 | eustea cites, massine grantings sunten |
| | Conditions, If any, which) DUE TO (Struck by vel | siala (i) 1 |
| | gave rise to immediate | acce (s) |
| | cause (a), stating the DUE TO | |
| 1_ | underlying cause last. (c) | RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY |
| CERTIFICATION | PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT | RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPST YES NO |
| E | 20a. EXTERNAL CAUSE WAS PRIMARY Ø OF CONTRIBUTING □ CAUSE OF DEATH. Struck by vehice | OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |
| E | CAUSE OF DEATH. Struck by vehice | 200 (8) |
| | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20a | . PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| MEDICAL | Hour same while - Not While - | factory, street, office bldg., etc.) - 40 6 mi east Cumberland, Allegany Md. |
| Z | 6:05 p.m. Jan. 20,19 67 at work at work X | t. 40 6 mi. east Cumbercana, Accegany Ma. |
| | 21. I certify that I took charge of the remains described above | |
| | death resulted from: Natural causes , Accident X, | Suicide , Homicide , Undetermined manner |
| | 1 1 1/1 | CHIEF MEDICAL EXAMINER 1/23/67 |
| 1 | SIGNATURE Suldion Skelarel | M.D. ASSISTANT MEDICAL EXAMINER Rt. # 9 |
| | | |
| 1 | EXAMINER'S Benedict Skitarelic, M. D. | Address (Street, city, town, or county) |
| 23 | a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEME | TERY OR CREMATORY 23d. LOCATION (City, town or county) (State) |
| | Burial 1/23/67 Glendale C | emetery Flintstone, Allegany, Md. |
| 20 | 4. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| 3 | H. Wayne George Cumberland, Marylan | IAN 25 1961 |
| 5 | no magne veorige compensation, mary cont | DATE |

The second control of Participation of the second pa HIS TORREST TO STATE OF A STATE OF THE PROPERTY OF THE The second of th

| The same of the sa | MARYLAND STATE DEPARTMENT OF HEALTH OCUMUSION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, N | ARYLAND |
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| r death. | CERTIFICATE OF DEATH 00 | 045 |
| rer death. | 1. PLACE OF DEATH ATTUGARY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: R a. STATE Maryland Maryland | LEGANI |
| hours aft | b. CITY OR TOWN (if outside corporate limits, write RURAL write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL corp | end give nearest town |
| | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospite), give street address d. STREET ADDRESS | e. IS RESIDENC |
| 1 | Sacard Heart Hospital RD.#5 Box 186. | DN A FARM? |
| | 3. NAME DF First Middle Last 4. DATE Month DF (Type or print) Vallie V. McKinley DEATH | Day Year |
| | 5. SEX 6. CDLDR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER last birthday) Months WIDOWED DIVORCED 9/21/88 1896 770yrs. | 1 YEAR IF UNDER 24 HR Days Hours Min. |
| | 10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS PROSPT 11. BURTHPLACE (County & State, or Toreign Country) 12. C. | ITIZEN DF WHAT |
| | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME VIOLA | 5A |
| | Edward Bowman 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. 17. INFORMANT Address | |
| | (Yes, no, or unknown) (If yes give war or dates of service) No | |
| | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction | 13 days |
| | Conditions, If any, which by Rheumatic heart disease | 51 yrs. |
| | gave rise to immediate cause (a), stating the underlying cause last. DUE TO Virus pneumonia | 7 days |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTDPSY PERFORMED? |
| | DO DE CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NOTE | YES ND |
| İ | NOME | |
| | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (Country of the country of th | unty) (State) |
| | 21. I certify that (I) (this hospital) attended the deceased from December 22,19 62, to January 189 | 67, that (I) (we) las |
| | say the deceased alive on Jan. 18, 19.67, and that death occurred all 0.50M, Rum the causes and on the cause | he date stated above ATE SIGNED |
| | amo / Aceinan m. ATTENDING MED. STAFF DIRECTOR DIRECTOR DIPHYS. 1-2 | 0-67 |
| | PHYSICIAN'S NAME (Type) James P. Hallinan, M. D. 22d. ADDRESS 140 Bedford St., Cumberland, | Md. |
| | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or con | unty) (State) |
| | Burial Jan 21 1967 Hillcrest Burial Park Near Cumberland, | 'S SIGNATURE |
| | John J. Hafer, Jr. 230 Balto Ave. Cumberlandar 23 1967 furantes | Judge |
| | Md | |

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James F. Hallingn, M. D. 140 Bedford St., Ounberland, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00046 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 00046 HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY 2, and 3 ta PM3. Page o. STATE b. COUNTY Allegany af Maryland Allegany after death. MARYLAND Department b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. DOA Cumberland Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Office alang with farm within 72 hours Sacred Heart 109 Park St. State I in Item 18. Give Pages YES \ NO T haurs after death. NAME OF Last Middle First 4. DATE Doy Year DECEASED McVicker Austin 19 67 (Type or pnnt) DEATH F 15 January S. SEX 9. AGE (In years 6. COLOR OR RACE B. DATE OF BIRTH IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthday) Months Dovs Hours May 19 1886. Male Shite WIDOWED DIVORCED event 10a. USUAL OCCUPATION (Give kind af work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? RAIL COACE any RALROAD pages in any pencil 14. MOTHER'S MAIDEN NAME be executed within mc Vicker eITZ and Address 4601 Bayand 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) I(If yes give wor or dates of service) remaval, 172.18-3664 pending PITTSburg 13 NO 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH ar Coronary Occlusion IMMEDIATE CAUSE (o) This certificate shauld e, writing the ward forwarded ta the Ch crematian, DUE TO Conditions, if ony, which gove Coronary Sclerosis rise to immediate couse (a), DUE TO stoting the underlying couse lost. burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? the certificate. ţ YES 🗌 NO T 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) agent, priar PRIMARY Or CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) may be retained for your FUNERAL DIRECTOR: Page 19 at work at work designated 21. I certify that I took charge af the remains described above, held on Autopsy ... Inspection X, Inquiry T, ond in my opinion the funeral directar. death resulted from: Natural causes Accident Suicide . Hamicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY DEPUTY MEDICAL EXAMINER I January **EXAMINER'S** Benedict Skitarelic. 5 may b M.D. Address (Street, city, town, or combined Maryland NAME (Type) 23o. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) 23d. LOCATION (City or Town) Rockwood EMERSET 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15ME (5) DATE JAN 6M 1/66

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N Jamery 15, 1967 Cumberland, hardend

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death ond completely filled in by the funeral remove corbon papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY b. COUNTY ALLEGANY PENNSYLVANIA MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) ond in ony event, within 72 hours FAIRHOPE 2 DAYS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS MEMORIAL HOSPITAL YES NO pleose remove corbon 3. NAME OF First Middle Last 4. DATE Manth Year Day DECEASED MARTE 24 TTNA MERKEL JANUARY 19 67 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH **NEVER MARRIED** lost birthday) Months Days Haurs WHITE 1-22-1967 FEMALE WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind af work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY the ottending physician sit permit. Their please MEYERSDALE. PA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removol, CHARLES MERKEL BETTY BUTLER 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, ng, grunknawn) (If yes give wor ar dates af service) MEMORIAL HOSPITAL-CUMBERLAND. MD. buriol, cremation, CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN Neverous System Bleeding burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) signed by Page 4 may be retained by the hospital or ottending physician. DUF TO Conditions, if ony, which gave rise ta immediate couse (a). DUE TO stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been as the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City ar town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, affice bldg., etc.) Haur o.m Not While of wark at wark 21. I certify that (I) (this haspital) attended the deceased fram 2:13M, from causes and an the date stated abave. 19____, that (1) (we) last director, page 3 snoura should be filed with the and that death accurred at saw the deceased alive an. 22b. DATE SIGNED 22a. SIONATURE MED. DIRECTOR **ATTENDING** M.D. PHYS. PHYSICIAN'S GREENE ST., CUMBERLAND, MD. ROBERT DO BRODELL NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY Jan. 27, 1967 23d. LOCATION (City or Town) 230. BURIAL, CREMATION, Buring (Specify) (County) (State) Hyndman Cemetery Hyndman Bedford Co REGISTRAR 2Sb. REGISTRAR'S SIGN 2Sq. REC'D BY REGISTRAR ADDRESS PUNERAL DIRECTOR VR A15 (4) Hyndman . PA. 196

OF CEREDALE, LAR. SELECTION D. S. A.

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MARYLAND STATE DEPARTMENT OF HEALTH OUTPUT OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 00049

| OLK II I I CAT | OF DEATH | |
|--|---|---|
| 1. PLACE OF OEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, If institution: F | Residence before admission) |
| Allegany | a. STATE Maryland b. COUNTY A | llegany |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL | |
| Curiberland | Cumberland | 11.1 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | d. STREET AOORESS | e. IS RESIDENCE |
| Sacred Heart Hospital | 661 Greene St. | ON A FARM? |
| 3. NAME OF First Middle OCCEASEO | Last 4. DATE Month OF | Day Year |
| (Type or print) Mary Elizabeth | Miller DEATH 1 | 4 19 67 |
| 7. MARKIEG METER MARKIEG | | 1 YEAR IF UNDER 24 HRS |
| Female White WIOOWED TO DIVORCEO | 7/18/86 last birthday) Months | Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, Own home | | OUNTRY USA |
| 13. FATHER'S NAME | 14. MOTHER'S MAIOEN NAME | |
| William Murphy | Mary Scalley Murphy | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. | INFORMANT Address | - D / . / . |
| (Yes, no, or unkown) No | patient's chart Mrs. Edward 1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN |
| PART 1. OEATH WAS CAUSEO BY: Alana Cause (a) Cause and any selection | won | 6 u 11 |
| Hall DUE TO | | e) |
| Cenditions, If any, which) (b) Releasely | in | Lifery |
| gave rise to immediate cause (a), stating the OUE TO | | 0 |
| underlying cause last. (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA | TED TO THE TERM INAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY PERFORMED? |
| | | YES NO |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO CAUSE OF OF THE SIGNIFICANT CONTRIBUTING TO CAUSE OF OF THE SIGNIFICANT CONTRIBUTING TO CAUSE OF OF THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE SIGNIFICANT CONTRIBUTING TO THE SIGNIFICANT CONTRIBUTION CONTRIBUTING TO THE SIGNIFICANT CONTRIBUTION CONTRI | RRED. (Enter nature of injury in Part I or Part II of Item 18 | 3.) |
| | CE OF INJURY (Home, farm, 20f. (City or town) (Co | unty) (State) |
| Hour a.m. While Not While factor | y, street, office bldg., etc.) | |
| | 2 | 0 |
| 21. I do not the track to the dood to do | | 2, that (I) (we) last |
| saw the deceased alive on 1947, and that | death occurred atM, from the causes and on t | ne date stated above. Date signed |
| pen Bring M.D. | ATTENDING MED. STAFF DIRECTOR PHYS. | 7-67 |
| 22c. PHYSICIAN'S NAME (Type) Lewis Brings, M.D. | 22d. ADDRESS 57 Greene St. Cumberland, 1 | ld. |
| 23a. BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY | OR CREMATORY 23d. LOCATION (City, town or co | unty) (State) |
| REMOVAL (Specify) Burial 1/7/67 SS. Peter & P | aul Cem. Cumberland, Alled | anu Md. |
| 24. FUNERAL DIRECTOR AOORESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR | 'S SIGNATURE |
| H. Wayne George Cumberland, Md. | DATE JAN 10 1967 Aclia | refor Ouder |
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00050 executed within 24 hours after death and PLACE OF DEATH campletely filled in by the funeral ave carban papers. Pages ond 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE h COLINTY ALLEGANY MARYLAND ALLEGANY c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, FROSTBURG WEEKS R.F.D. 2. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS MINERS HOSPITAL FROSTBURG 3. NAME OF Middle First 4 DATE Manth Last Day DECEASED HOWARD W. MYERS (Type or print) DEATH JAN S. SEX 6. COLOR OR RACE AGE (In years B. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** ease remave last birthday) Months MALE WHITE WIDOWED DIVORCED 10,1890 76 yrs. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? andi BOLT & FORGE DEP RATTROAD ECKHART MARYT.ANT 0 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 0 WILLIAM MYERS SARAH DUDLEY

c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? NO Y YES | Year 19 67 IF UNDER 24 HRS Hours 12. CITIZEN OF WHAT WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT FROSTBURG, MD. 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war ar dates of service) PERRY MYERS. BRADDOCK ESTATES CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate couse (o), DUF TO stating the underlying couse lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Yeor (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) at wark at wark 21. I certify that (1) (this hospital) attended the deceased from 14 . 1967, to 17 . 1967, that (1) (we) last 19.67, and that death occurred at 3.55 M, from causes and on the date stated above. saw the deceased alive on. 22a, SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL CREMATION. (County) (Stote) REMOVAL (Specify) ECKHART CEMETERY

requires that the death certificate be burial-transit signed this certificate has been the d TO FUNERAL DIRECTOR: After be retained directar, shauld VR A15 (4) 20 M 1/66

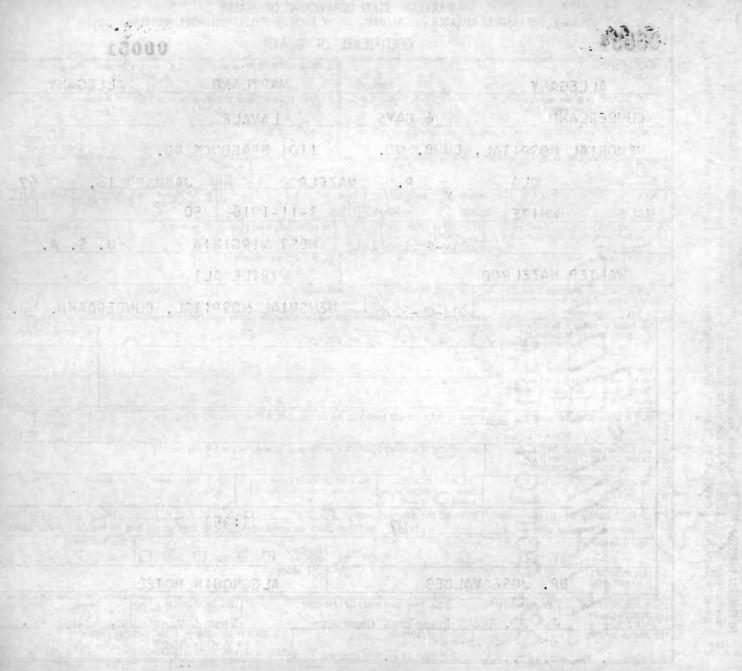
ECKHART MARYT, AND 25b. REGISTRAR'S SIGNATURE

MAIN FROSTBURG

2So. REC'D BY REGISTRAR

C. 19/10-1-1 A TOTAL SECTION OF THE PROPERTY OF THE SECTION OF T Mary Bell William Charles . OF LEWISTINGS The state of the s The state of the s THE TOTAL SERVICE OF THE SERVICE OF

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00051 CERTIFICATE OF DEATH 00051 and campletely filled in by the funeral remave carban papers. Pages 1 and 2 death executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY b. COUNTY o. STATE ALLEGANY papers. Pages 1 nin 72 hours after MARYLAND b. CITY OR TOWN (If outside carporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give neorest town)
CUMBERLAND DAYS I AVAL F d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS S RESIDENCE hin 72 h ON A FARM? MEMORIAL IIOI BRADDOCK RD HOSPITAL CUMB. MD. NO YES × × 3. NAME OF Middle First Last 4. DATE Manth Doy Year DECEASED OLA NAZELROD 67 Type or print JANUARY 19 DEATH S. SEX 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED 8. DATE OF BIRTH **NEVER MARRIED** birthday) Manths Days Hours and in any MALE WHITE WIDOWED DIVORCED 3-11-1916 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. 8IRTHPLACE (Caunty & State, or foreign cauntry) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? please **INDUSTRY** physician WEST VIRGINIA lv-Springfield Trucker 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal, Then WALTER NAZELROD MYRTLE ALT The law requires that the death cert 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dates af service) MEMORIAL HOSPITAL, CUMBERDAND. MD. 214-07-3290 crematian, No INTERVAL SETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED 8Y: ONSET AND DEATH IMMEDIATE CAUSE (a). þ physician. DUE TO this certificate has been signed burial, dente carcenona (retur Conditions, if ony, which gove rise to immediate cause (a). DUE TO far use as the t f Heolth prior tab stating the underlying couse be retained by the hospital or attending last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO YES 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II) of item 18.) OR CONTRIBUTING CAUSE OF DEATH d. detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Manth, Day, Year (Caunty) factory, street, affice bldg., etc.) Nat While O FUNERAL DIRECTOR: After at wark at work - Den 21. I certify that (I) (this hospital) attended the deceased fram. 1965, that (1) (we) lost 1960 , and that death accurred at 3:35 Mram causes and an the date stated above. saw the deceased alive an 1 -22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** lece M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) DR. JOSE VALDES ALGONOUIN HOTEL directar, p 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Near Cumberland. 1967 Nazelrod Cemetery Md Buria 2So. REC'D 8Y REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 harles 1967 Banto Cumber landDATE



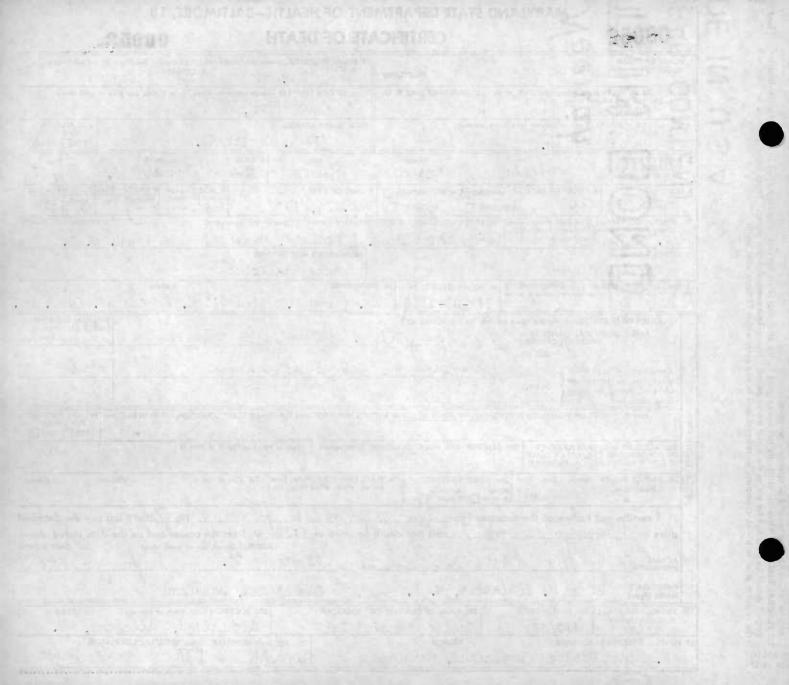
VS A15 (4) 15M 10/57

00052

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

00052No.

| | . PLACE OF DEATH o. COUNTY | Allegany | | MARYLAN | ITATE O | | | d lived. If instituti b. COUNTY | 100- | ce before odm gany | ission) |
|----|---|--|--------------------|--|-------------------------|-----------------------------------|------------------------|---|--------------------|-----------------------|-------------------------------|
| 1 | b. CITY OR TOWN (I RURAL ond give no Cumbe) | | ts, write | c. LENGTH OF STAY IN | | or town (IF | | orate limits, write R | URAL ond g | give nearest to | wn) |
| | d. NAME OF HOSPIT OR INSTITUTION | AL (If not in hospitol, g | ive street o | address) | | ET ADDRESS | Centre | 2 St. | | ON | ESIDENCE A FARM? |
| | NAME OF DECEASED (Type or print) | Will | iam | Middle Wesley | Ü | lost ten | 4. DATE OF DEATH | Mor Janu | | Day 4, | Year 19 67 |
| | s. sex Male | 6. COLOR OR RACE White | 7. MARRI WIDOWE | IED NEVER MARRIED | _ 0 | BIRTH 190 | 0 | 9. AGE (In years lost birthday) 66 yrs. | IF UNDER Months | Days Hour | |
| | Ret. meter | king life, even if retired | | kind of Business or 11 ity Water De | pt. Ec | khart, | Maryl | | | IZEN OF WH | AT COUNTRY? |
| ľ | 3. FATHER'S NAME | 244 | | | | ER'S MAIDEN | | | | | |
| - | Patrick 5. WAS DECEASED EVE | <u> </u> | ccea ly | COLUMN TO THE T | A) | ine Kre | itzbur | -G Add | lana | | • |
| | Yes, no. or unknown) | (If yes, give wor or dotes of s | ervice) | | | ema M. | Often | 417 N. C | | St. Cu | unb. Md. |
| | | mmediate (| 1 | Multi- | funt i E, | V, fl | is en | ~ , | | INTERNAL ONSET AN | DO DEATH |
| 7 | PART II. OTI | HER SIGNIFICANT CON | | ONTRIBUTING TO DEATH | | | | | VEN IN PAR | PER | S AUTOPSY FORMED? NO M |
| | | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC | CRIBE HOW INJURY OCCI | JRRED. (Enter natu | ere of injury in | Part I or Por | t II of item 1B.) | | | |
| | 20c. TIME OF INJUR Hour a. m. p. m. | Y Manth, Day, Ye | While | NJURY OCCURRED 204 Not while at wark | factory, street, | RY (Home, far office bldg., et | m, 20f. (Cit) | y ar tawn) | (0 | Caunty) | (State) |
| , | 21. I certify the alive on | Blane M. S | 296 Rh | . 1 | , 19.1 eath occurred | 43 Gre | ene St | the causes of treet, city or town, | and an tl | | e deceased above. DATE SIGNED |
| 1 | PO BURIAL, CREMATIC REMOVAL (Specify) | |)F | 200. NAME OF CEMETER Sunset Memo | | | | TION (City, town, | 100 | | tate) |
| 1: | BURLAL. 3. FUNERAL DIRECTOR H. Wayne | 'S SIGNATURE | unber | ADDRESS land, Maryle | | | JAN 1 | | STRAR'S SIC | SNATURE | rege |



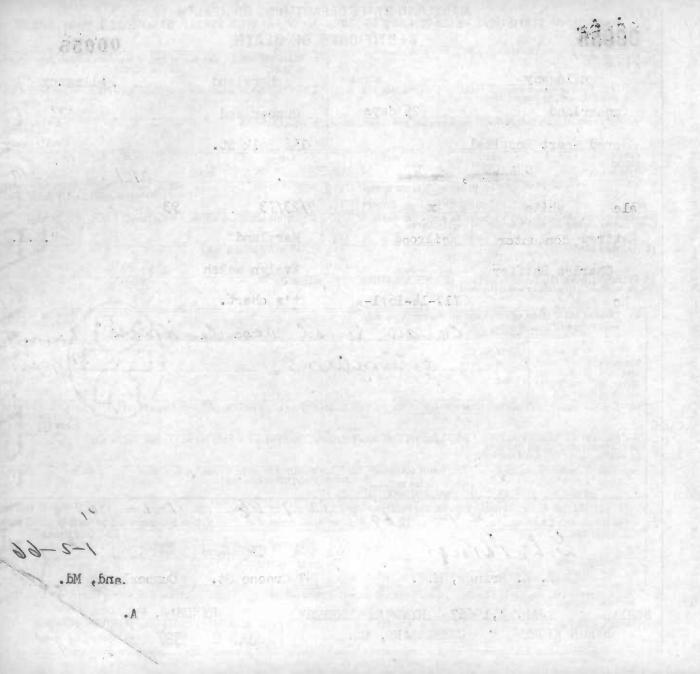
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Rasidence bafora edmission) e. COUNTY s necessary, rector. Page your files. d of Health, Allegany Maryland Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) cumberland your do of DOA Ellerslie d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat addrass) d. STREET ADDRESS a. IS RESIDENCE ON A FARM Memorial Hospital YES NO PO 3. NAME OF 4. DATE Middle Month Yeer DECEASED to the Gilbert Charles DEATH January 26, 1967 Pfitzenmayer (Type or print) 2, and 3 to the 5 may be refined 2 with the 2 hours after 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) Months Hours MALe White October 31, 1906 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Giva kind of work 10b, KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Give Pages 1, 2, orm PM3. Page done during most of working life, even if retired) Carpenter Carpentry Cumberland, Md. USA pages | within 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Magdalene Pitzenmayer File event 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (If yes give war or detes of service) No Mrs. Helen Pfitzenmeyer, Ellerslie, Md. 214-07-5313 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN along PART I. DEATH WAS CAUSED BY: Coronary occlusion " in pencil i Office alor IMMEDIATE CAUSE (e) burial-t DUE TO removal Coronary sclerosis Conditions, if any, which the word "pending" in Medical Examiner's O should be used as a bu gave rise to immadieta causa DUE TO (e), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(10) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter netura of injury in Part I or Pert II of itam 18.) C PRIMARY | or CONTRIBUTING | CAUSE OF DEATH the Chie. writing Chief / 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (Stata) fectory, street, office bldg., etc.) While Not While WED et work et work ertificate, orwarded to the pri 21. I certify that I took charge of the remains described above, held an Autopsy | Inspection X Inquiry and in my opinion forwarded death resulted from: Natural causes X. Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED lease execute should be for FUNERAL 1 DEPUTY MEDICAL EXAMINER DEPUTY EXAMINER'S Benedict Skitarelic Address (Street, city, town, or county Cumberland, RD#9.Md. NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) Burial (Specify) Cash Valley Road, LaVale, Md. 29,1967 240 g Rest Lawn Memorial Gardens 246 REGISTRAPHS SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR FUMERAL DIRECTOR VS. AISME y Hyndman, Pennsylvania DATE 5M 9/60

22900 Carles Tribe and the tribe and the control of . El, Lyseffe ed ent att of the state o Selection Date in a supple Jun. 29,1982 Shert I ver American Carrisons Described Manager Mondale, to.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00054 CERTIFICATE OF DEATH 00054 requires that the death certificate be executed within 24 hours after death and campletely filled in by the funeral remove carban papers. Pages 1 and 2 pressy event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Maryland Allegany Allegany MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carporate limits, write RURAL and give negrest town Cumber land 7 yrs. d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 905 Glenwood Street Sylvan Retreat YES TO NO ! 3. NAME OF Middle 4. DATE Dov Year Lost DECEASED Matilda Rodney January 67 Emily 19 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE X B. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED lost birthday) Months Dovs Hours remov Female White WIDOWED DIVORCED Dec. 4. 1883 11. 8IRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR physician a nen please aval, and P COUNTRY? INDUSTRY during most of working life, even if retired) U.S.A. Maryland

14. MOTHER'S MAIDEN NAME Salad Dietician Sheehe Restaurant 13. FATHER'S NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval, Annie Wise James R. Rodney attending permit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Md (Yes, no, or unknown) (If yes give wor or dates of service) 214-05-8593 924 Glenwood St Cumberland no Sally C. Moats. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying cause 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) be detached far use State Dept. af Heolth 408 NO F O HOSPITAL OR ATTENDING PHYSICIAN: 1 Page 4 may be retained by the haspital ar certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year FUNERAL DIRECTOR: After this foctory, street, office bldg., etc.) Hour o.m. Not While of work ot work 1959 to Jan. 27 . 190 (, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased fram UCT. and that death occurred at 8 A M, from couses and on the date stated above. directar, page 3 should shauld be filed with the Jan. 26 1967 saw the deceased alive on. 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. ATTENDING MED. DIRECTOR M.D. PHYS. 49 Greene Street, Cumberland, Md. 22c. PHYSICIAN'S L. B. Mathews, M.D. NAME (Type) 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) om Cumberland 250. REC'D BY REGISTRAR 256 R Burial 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 196/ -Ave. Cumberland DATE. Balto

32000 end sinne - a first to the contract of the contract of The state of the s Class in one D. Tables over S. N. Historia and J. P. C.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CEDTICICATE OF DEATH

DOOSE

| | 00000 | | | CERTIFICA | MIL | OI DEATH | | | 000 | U | | |
|-----------------------|--|--|-----------------|--------------------------------|--------|---|------------------|-------------------------------|--------------------|--------------------|------------------------|---------------|
| | PLACE OF DEATH | | | | | 2. USUAL RESIDENCE | , | ed lived, if instituti | TV | | | on) |
| 1 | a. COUNTY All | egany | | MARYLAN | D | o. STATE Mar | yland | b. COUP | "' A] | lleg | any | |
| | b. CITY OR TOWN (| f autside carparate limit give nearest tawn) | s, | c. LENGTH OF STAY IN 18 | | c. CITY OR TOWN (If o | | te limits, write RUF | RAL and give | e neares | t tawn) | |
| | | erland | | 59 years | | La | Vale | | 01 | 1/ | | |
| - 1 | | AL OR INSTITUTION (If n | ot in hospital, | give street address) | | d. STREET ADDRESS | | | | | e. IS RESID | DENCE ARM? |
| ľ | Sacr | ed Heart Ho | spital | | | 9 | Asbury | Avenue | | | | NO 🔀 |
| | NAME OF DECEASED | F | irst | Middle | | Last | 4. DATE OF | Mant | | Day | Yeo | |
| | (Type or print) | Anne | | К. | | Sheakley | DEATH | 1 | | 6 | | 67 |
| | SEX | 6. COLOR OR RACE | 7. MARRIED | | 3 [| B. DATE OF BIRTH | 9. | last birthdoy) | IF UNDER Manths | Days | IF UNDER Hours | Min. |
| | Female | White | WIDOWED | | | 3/27/07 | | JJ Yrs. | | | | |
| 0a | ing mast of working | (Give kind of work dane | | (IND OF BUSINESS OR NDUSTRY | | 11. BIRTHPLACE (Count | | | | TIZEN OF UNTRY? | | |
| | ing mast of working | Wile | On | nDustry n Home | | - | ny Co. | , Md. | | | USA | |
| 3. | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN | | | | | | |
| | John D | | | | | | Hewitt | | | | | |
| IS. (Ye | . WAS DECEASED EVE es, na, ar unknawn) | R IN U.S. ARMED FORCES? (If yes give war ar dates | at service) | SOCIAL SECURITY NO. | 17. 1 | NFORMANT | 1 | Addre | ess | | | |
| | no | | | 212-10-0141 | | Patient' | s char | T | | | | |
| | 18. CAUSE OF DI | ATH (Enter only one co H WAS CAUSED BY: | use per line fa | r (a), (b), and (c).) | , - | 0-0+ | 2 2 | 10 | 0 | | ERVAL BET SET AND D | |
| | 1/23 1 | IMMEDIATE CAUSE | (a) (de | ute und | ra | clilar | allen | the | luve | n | usu | to |
| | tax! | | 10 | 0. 1 | | p. (). | 0 - | P 0 - | | 4 | 1. | |
| | Conditions, if ony rise to immediat | a causa (a) | (b) (5 | Morroscle | 10 | u , , | kear | alsea | el. | 1 | gr | 0 |
| | stating the underlying cause DUE 10 | | | | | 1 Since | | | | 4 | and | 2 |
| | last. | , | (c) <u>C</u> | My weres | - | THE TENNING DISTAGE OF | AND THOM ONE | N IN DARY 1/-1 | | 110 | WAS AUTO | ODCV |
| 5 | 10 . | Α | | TO DEATH BUT NOT RELATED | 0 10 1 | (1-e 1) - | -10 | 0 0. | 1 - | | PERFORM | ED? |
| Š | Lieb | | | Carumana, | 7 | he fregat | - | wel eff | eiser | ~ 1 | ES [| NO D |
| WEDICAL CERTIFICATION | | CAUSE OF DEATH MEDICAL EXAMINER) | 205. 1 | DESCRIBE HOW INJURY OCCUP | KKED. | Enter noture of injury in | n Port I of Par | r II at item 18.) | | 2.3 | | |
| ריוחור | 20c. TIME OF INJU Haur a.i | | Whil | e Nat While | | CE OF INJURY (Hame, for ary, street, affice bldg., etc | | (City or tawn) | (Co | unty) | | (State) |
| | p.i | n. 19 | | irk Lat wark La | | 2/10 | 10/(/+ | 2 0 2 | 10/ | 17 +1 | at (1) (| wa) la |
| | 21. I certify that (I) (this haspital) attended the deceased fram way, 1964, to 5, 1967, that (I) (we) las saw the deceased alive an 1967, and that death accurred at 6-30AM, fram causes and an the date stated abave | | | | | | | | | | | |
| | 226 SIGNATURE M.D. ATTENDING MED. STAFF 1667 | | | | | | | | | | | |
| | 22c. PHYSICIAN'S NAME (Type | Dr. Thom | as F. | Lewis, M.D. | 50 | 22d. ADDRESS OO Greene | St., C | umberla | nd, N | la. | | |
| 230 | a. BURIAL, CREMATIO | ON. 23b. DATE TH | HEREOF | 23c. NAME OF CEMETER | Y OR | CREMATORY | 2 <u>3</u> d. LO | CATION (City or To | wn) | (County |) (5 | State) |
| | BREMOYAL (Specify | | | | | urial Park | Cum | CATION (City or To berland | ,Md.A | lle | gany | |
| 24 | 4. EUNERAL DIRECTO | R | | ADDRESS | | 2Sa. REC | C'D BY REGISTE | RAR 25b RI | GISTRA | SIGNATI | SE Ou | det |
| | James F | . Scarpel. | li, Cu | mberland, Md | | DATE | JAN] | 1 1961 | 1 | | 1 | 0- |

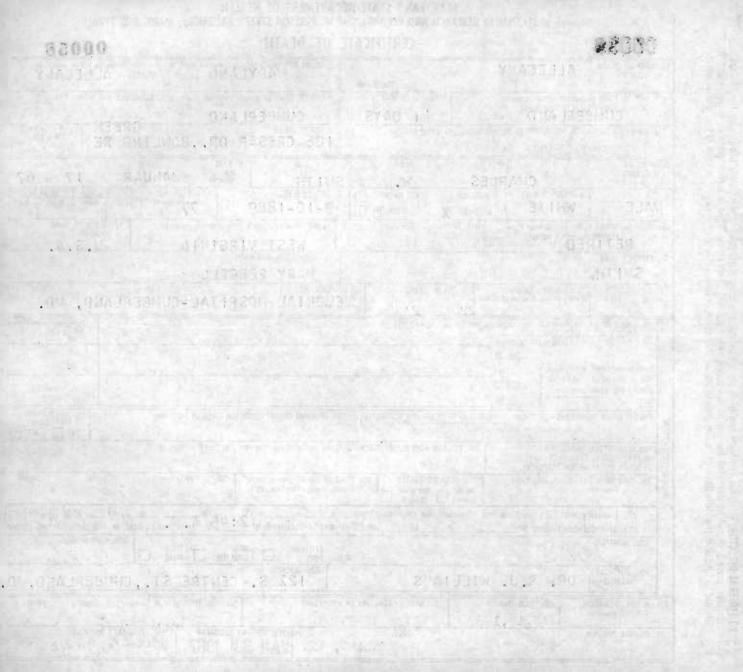
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 should be filed with the State Dept. af Health priar ta burial, crematian, ar remaval, and in any event, within 72 hours after death O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 20 M 1/66

. 46000 CALIFORNIA LENGTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission) 1. PLACE OF DEATH a. COUNTY · · SMaryland rector, Page Health, Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) Lonaconing, RD. Harpersville 6 Lonaconing, RD- Harpersville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS State Boar e. IS RESIDENCE be retained for ON A FARM? YES NO X 3. NAME OF Middle 4. DATE Month Dev ithin 24 hours e...
5. Give Pages 1, 2, and
F. Give Page 5 may be 1...
PM3. Page 5 may be 1...
72 hours after de DECEASED OF JAMES (Type or print) SMALL DEATH 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH AGE (in yours | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Male WIDOWED 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (Stella or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired)
West Virginia Pul Barton, Md. Paper CO. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Symons James IS. WAS DECEASED EVER IN U.S. ARMED FORCES? permit, Fi 16. SOCIAL SECURITY NO.1 17. INFORMANT Address (Yes, no, or unkown) (Ifyesgive werordetasofservice) Mrs. Letitia Small Lonaconing, 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), Office along burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Gunshot of left chest IMMEDIATE CAUSE (a) Minutes DUE TO (self-inflicted) gava rise to Immediate cause Medical Examiner's 10 DUE TO (a), stating the underlying cremation, PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 8 NO 0 plnods 200. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of Injury In Pert I or Part II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH, 3 MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) should be forwarded to the Chi FUNERAL DIRECTOR: Page (County) (Stete) factory, street, office bldg., etc.) While Not While Hour e.m. at work at work 21. I certify that I took charge of the remains described above, held an Autopsy XI. Inspection Inquiry X and in my opinion designated agent, Accident Suicide (death resulted from: Natural causes Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DATE SIGNED DEPUTY MEDICAL EXAMINER Benedict Skitarelic, M.D. Address (Street, city, town, or counts Cumberland,
2b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or country) 22b. DATE THEREOF 22a, BURIAL, CREMATION. REMOVAL (Specify) ₽40 p 1967 Sunset Memorial Park Dumberland, MD. Burial 23. FUNERAL DIRECTOR 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VS. AISME GEORGE EICHHORN Lonaconing, MD.

Eight in the state of the state Leckconing, w- Carperoville town in a later and a series of a company in a Larry Principal · And Carried Complete Company of the following of and a series of the series of sorted 1 11 1 15 1967 Sunsen besorted rank Ou bordand, all. .us .nminoceno. .aksaull Rebuilder



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00059 CERTIFICATE OF DEATH 00059 2 executed within 24 hours ofter death. completely filled in by the funeral nove corbon popers. Pages 1 and 2 veent, within 72 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH Allegany o. COUNTY ALLEGANY MARYLAND b. (ITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn)

Frostburg c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Lonaconing
d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) Miners Hospital Church Street YES NO 3. NAME OF Middle Year remove corbon DECEASED (Type or print) **JENNIE** SMITH /23/1967 DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Manths Days Female White Feb. 17th. WIDOWED DIVORCED physician and 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during mast of working life, even if retired) INDUSTRY Longconing, MD

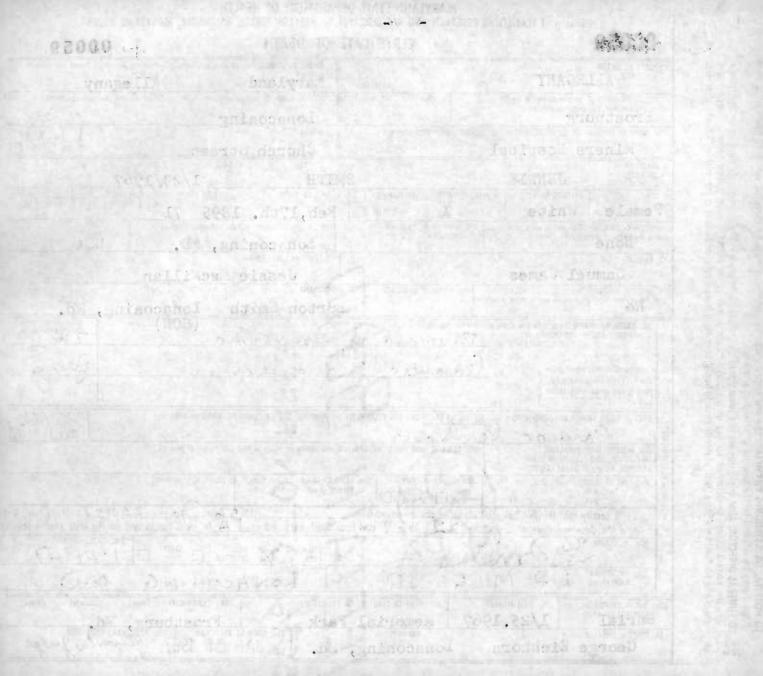
14. MOTHER'S MAIDEN NAME requires that the death certificate. 13. FATHER'S NAME or removo Samuel James Jessie MacMillan 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, ne prunknown) (If yes give war or dotes af service) Burton Smith Lonaconing. Md. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if any, which gove rise ta immediate cause (a) DUE TO stating the underlying cause the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been as the PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPS) PERFORMED? NO Por 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 1B.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, (City ar town) (County) (State) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, affice bldg., etc.) at work at work 21. I certify that (I) (this hospital) attended the deceased fram. 19.56 ta ron 23, 1967, and that death accurred at AM, from causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. MED. DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S director, po ONACONIN NAME (Type) 23d. LOCATION (City or Town) (Stote) 23c. NAME OF CEMETERY OR CREMATORY (County) 23b. DATE THEREOF 23a. BURIAL, CREMATION BREMOVAL (Specify) 1/25.1967 Memorial Park Frostburg Md

25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR

Lonaconing, Md.

George Eichhorn

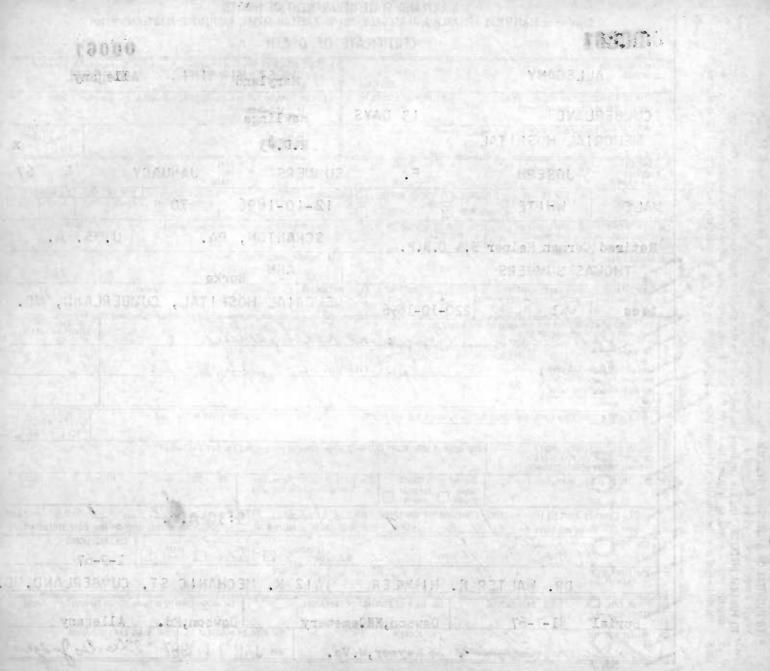
Charles



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00060 CERTIFICATE OF DEATH 00060 certificate be executed within 24 haurs after death. death ician and campletely filled in by the funeral lease remave carban papers. Pages 1 and and in any event, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Allegany Maryland o. COUNTY b. COUNTY Allegany MARYLAND c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, 4/6/1963 Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Allegany County Infirmary 1105 Michigan Avenue YES NO X NAME OF Middle 4. DATE Manth Dov Year Smith DECEASED Maude Lena 2, 19 67 January DEATH (Type ar print) YEAR IF UNDER 24 HRS. AGE (In years IF UNDER S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Manths Dovs 山/27/1883 Hours Female White WIDOWED X DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane during most of working life even if retired)
HOUSEWILE 11. BIRTHPLACE (County & Stote, or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT Own Home COUNTRY? the attending provicion Warnfordsburg. Pa. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Thomas Elliott McCullough Elizabeth Gardner 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ((If yes give wor or dates af service) 17. INFORMANTP.O. Box 599, Addres Cumberland, Allegany County Infirmary records. 16. SOCIAL SECURITY NO. AddressCumberland, Md. PHYSICIAN: The law requires that the death permit. 10 18. CAUSE OF DEATH (Enter only one cause per line for (o) (b), and (c)) My sexuality Cha, degeneration burial-transit signed by physician. Conditions, if ony, which gove rise to immediate couse (a). DUE TO Page 4 may be retained by the haspital ar attending stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been d far use as the af Health prior ta 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II af item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED factory, street, affice bldg., etc.) at wark 21. I certify that (I) (this haspital) attended the deceosed from 4/6/1963 saw the deceased plive an 12/31/66 19 ond that death occurred , 19 __, that (I) (we) last 3 should saw the deceased olive an. ond that death occurred at A. M, from couses and on the date stated above. 22a. SIGNATURE 6:20 22b. DATE SIGNED 1/3/1967 MED.
DIRECTOR M.D. director, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S B . Mathews, Lee 49 Greene St., Cumberland, Md. NAME (Type) 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Warfordsburg, Pa. Jan.5. 1966 Presbyterian Cemetery 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE **ADDRESS** 24. FUNERAL DIRECTOR
James F Scarpelli, umberland, Md. VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00061 CERTIFICATE OF DEATH 00061 by the funeral Pages 1 and 2 hin 72 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence hefore admission) ALLEGANY o. COUNTY RGIN Ab. COUNTAllegany within 24 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 DAYS Rawlings papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) MEMORIAL HOSPITAL completely filled in d. STREET ADDRESS e. IS RESIDENCE ON A FARM? R.D.#3 YES NO 3 and in any event, witl 3. NAME OF 4. DATE SUMMERS JANUARY JOSEPH DECEASED (Type or print) DEATH requires that the death certificate be executed S. SEX 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** 12-10-1896 lost Tim doy) MALE WHITE Months Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY SCRANTON, PA. ACOUNTER S attending physician sermit. Then please Retired Carman Helper B.& O.R.R. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME emov THOMAS SUMMERS ANN Burke 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL, CUMBERLAND, MD. burial, crematian, ar Yes 220-10-1896 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse be detached far use as the State Dept. af Health priar ta 10 FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) foctory, street, office bldg., etc.) Hour o.m. Not While ot work 21. I certify that (1) (this hospital) attended the deceased from. director, page 3 shauld should be filed with the 1962, and that death accurred at saw the deceased olive on_ M. fram couses and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED STAFF **ATTENDING** DIRECTOR PHYS. 1-9-67 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) MECHANIC ST. CUMBERLAND. MD WALTER N. HIMMLER 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial d. Allegany
25b. REGISTRAR'S SIGNATURE Dawson . MACemetery 1-7-67 Dawson Md. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Keyser W. Va.



ADDRESS

Westernport, Md.

2Sb. REGISTRAR'S SIGNATURE

REC'D BY REGISTRAR

VR A15 (4) 20 M 1/66 24. FUNERAL DIRECTOR

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TO FUNEKAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH OUUG3 OF STATIST

| MARIE OINIE DEI ARTIMETT | OI IIEAEIII |
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| ICAL RESEARCH AND RECORDS, 301 W. PRE | STON STREET, BALTIMORE 1, MARYLAND |
| CERTIFICATE OF DEA | ATH OOOGS |

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|---------------|-------------------------------|--|------------------|----------------------------|------------------|-----------------|------------------|---------------------------------|---------------|------------|---------------|
| 1. | PLACE DF DEAT a. COUNTY | Н | | | | | CE (Where det | ceased lived, If ins | | dence befo | re admission) |
| | Allega | anv | | MARYLAN | | TATE | I a | b. cour | | eral | / |
| | b. CITY OR TOW Write RURAL | N (if outside corpora and give nearest tow | ite limits, | c. LENGTH OF STAY IN | | OR TOWN (I | outside cor | porate limits, wr | Ite RURAL ar | nd give ne | earest/town) |
| | Cumber | | , | | | Par | v Paw | | | 85. | 3 |
| | | | ON (if not In ho | spital, give street addr | ess) d. STRE | ET ADDRESS | | | | | RESIDENCE |
| | Sagma | I Heart Hea | L2427 | | | c/o P | ostma | ston | | | A FARM? |
| 3 | NAME OF | Heart Hos | Irst | Middle | | | | | | YES | |
| 3. | DECEASED | | 11.21 | Middle | | ast | 0F | Monti | n . | Day | Year ' |
| - | (Type or print) | Guy | | 1 | VanHor | | DEATH | | | | 1967 |
| 5. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE | OF BIRTH | 9. | AGE (In years last birthday) | Months D | | NDER 24 HRS. |
| | Male | White | WIDOWED | DIVORCED [| 12/1 | 15/93 | | 73 yrs. | MOILLIS | ays HU | min. |
| 10: | a. USUAL OCCUPAT | TION (Give kind of work ing life, even if retire | done 10b. K | ND OF BUSINESS OR | 11. BIF | THPLACE (C | ounty & State, | or foreign country | y) 12. CITI | ZEN OF W | /HAT |
| uui | Retir | | ,u) | | Por | . Da | LT TT- | | US | | |
| 13 | . FATHER'S NAM | | | | 1 14. MC | THER'S MAII | DEN NAME | | 1 00 | 24 | |
| | M | Wantlown | | | | | | 1.7. 3.0 | 1 | | |
| 15 | | VanHorn EVER IN U.S. ARMED FO | DRCES? 16 | SOCIAL SECURITY NO. 1 | 17. INFORMA | | yrtle | Wolfor | | | |
| (Y | es, no, or unkown) | (If yes give war or dates | of service) | SOCIAL SECONTITIO. | | | | Addi C. | 33 | | |
| | No | | | | Patie | ent's C | Chart | | | | |
| | | | (1) | ne for (a), (b), and (c),] | 0 - | + 1 | | | | | ND OFATH |
| | PART I. DI | EATH WAS CAUSED BY IMMEDIATE CAUSE | | Durch | all | w | anes | urson | _ | Cm | mle |
| | 16.37 | DUE | 4 | 1 | | | | 1 | | , | |
| | Conditions, If | | | Maria | > hu | - Jan | | 0 | | 14/ | in |
| | gave rise to | Immediate (| (b) | 7 040 0000 | V | 100 | | | | 1 | |
| | cause (a), s | | | | | | | | | | |
| Z | Underlying caus | | (C) | TING TO DEATH BUT NOT | DELATED TO TH | C TCDMINIAL | DICEACE CON | DITION CIVEN IN | DART 1/o | 119. WA | S AUTOPSY |
| Ĕ | PARTIT. OTHERS | SIGNIFICANT CONDITT | ONSCONTRIBU | TING TO DEATH BUT NOT | KELATED TO TH | E TERMINAL | DISEASE COM | DILION GLASM IN | PARTI(a) | PER | FORMED? |
| FIC | | | | | | | | | | YES | NO 🗌 |
| CERTIFICATION | OR CONTRIBUT | WAS UNDERLYING ☐ ING ☐ CAUSE OF DEA TIFY MEDICAL EXAMI | TH NER) | ESCRIBE HOW INJURY | OCCURREO. (Er | iter nature o | f Injury in Pa | art I or Part II o | if Item 18.) | | |
| AL | 20c. TIME OF | INJURY Month, Day, | Year 20d. If | IJURY OCCURRED 20e. | PLACE OF INJ | URY (Home, f | arm, 20f. | (City or town) | (Count) | y) | (State) |
| MEDICAL | Hour a.i | | While | Not While | factory, street, | office bldg., e | etc.) | | | | |
| × | p.1 | m. 19 | at work | at work | A | 13 | 14 | 1 | 1 | , | |
| | 21. I certif | fy that (I) (this hos | patal) attende | d the depeased from | gang | r/, 1 | 9, to | my! | 1, 196/ | , that (| I) (we) last |
| | | ceased_alive_on | Juny 1 | 1 and | that death o | ccurred at_ | M, fro | om the causes | | | |
| | 22a. SIGNATU | RE / C | KIN | | 4 77 74 | DINO | MED | CTAFF | 22b. OAT | E SIGNED | |
| | 1181 | morning | un | | M.D. PHYS. | | MED. DIRECTOR | STAFF PHYS. | 4// | 1// | 7_ |
| | 22c. PHYSICIA NAME (T | AN'S | | | 22d. | ADDRESS | 43 Gr | eene St | | 1 | |
| | IAMALE (1 | Blane | M. Sh | indler | | | Cumbe | | Md. | | |
| 23 | | MATION, 23b. DATE | | 23c. NAME OF CEME | TERY OR CREM | IATORY | | CATION (City, to | own or count | y) | (State) |
| | REMOVAL (Sp | 1618 | /1967 | Camp Hill | Cem. | | Port | Paw. | | TAT | Vo |
| 24 | UN PRAIC DIBA | | 70.7 | ADDRESS | | 25a. RE | C'D BY REGIS | STRAR 250. R | EGISTRAR'S | SIGNATUR | REVEL |
| | . We | 6 Vansa | n | D 1 3 | W. Va. | | AN 20 | 1967 | Milan | Can Q | udas |
| 14 | ohnson(| Funeral | lomes. | Berkeley | Spgs. | DATE | 0 0 0 V | 198 | | 1 | - |

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Pottent's Chart

J Signature

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00064 00064 death. sate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) filled in by the funeral papers. Pages 1 and PLACE OF DEATH O. COUNTY LLEGANY b. COUNTY ALL EGANY hours after MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, DAYS 5. BOX 319-C. CUMBERLAND. MD. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Winchester Rd. and in any event, within 72 Trade Wind Trailer C. MEMORIAL HOSPITAL NO N 3. NAME OF 4. DATE leose remove corbon First Middle Lost Month and completely 1967 DECEASED VAN SICKL HARLEY JAN DEATH (Type or print) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthdoy) Months 11-2-1909 Hours WHITE MALE WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? U.S.A. Industry PA. Farminaton 11. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME buriol, crematian, or removol, ELIZABETH FAULKNER FNNIS VAN SICKLE Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT requires that the deoth permit. (Yes, no, or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL CUMBERLAND, MD. 163-22-677 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b); ond (c).) buriol-tronsit ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by Page 4 moy be retained by the hospital or attending physician. DHE TO Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse prior to O FUNERAL DIRECTOR: After this certificate hos been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN WE ART 1(0) 19. WAS AUTOPSY PERFORMED? CERTIFICATION for use of Health NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (1) (this hospital) attended the deceased from____ /. ta 3 should director, poge 3 should should be filed with the , and that death occurred at 15A M, from causes and on the date stated abave. saw the deceased alive on_ 22b. DATE GRED 220. SIGNATURE ATTENDING STAFF PHYS. M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S HIMMELWRIGH 33 VA. AVENUE. CUMBERLAND MD. DR. OVERTON NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (Stote) REMOVAL (Specify) Farmington, Fayette. Penna. 1/15/67 VanSickle Cemeter 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Cumberland, Md. Wayne George

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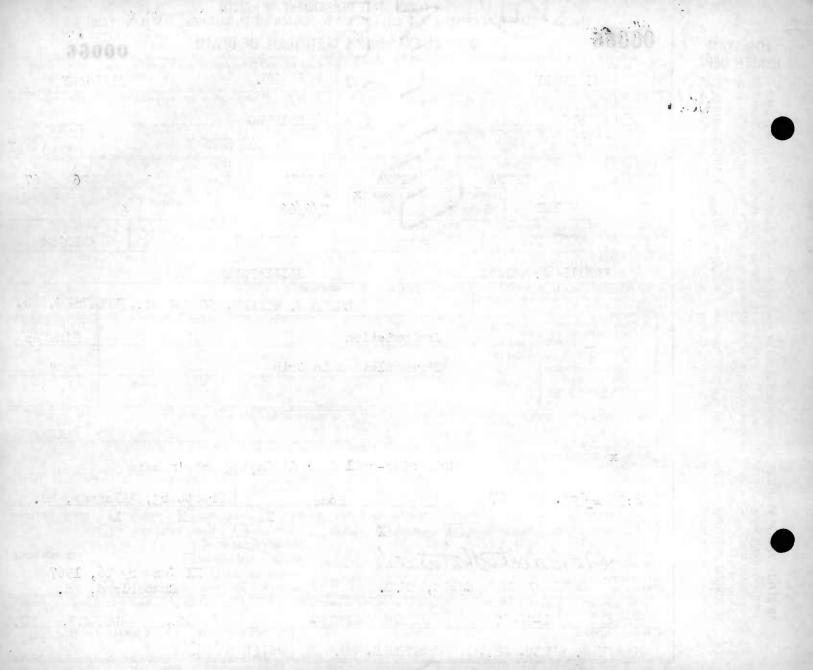
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 00065 00065 death. within 24 hours after death attending physician and campletely filled in by the funeral permit. Then please remave carban papers. Pages I and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY o. STATE ALLEGANY MARYLAND hours after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) CUMBERLAND 7 DAYS CUMBERLAND d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) and in any event, within 72 45 HENDERSON AVE. MEMORIAL HOSPITAL YES NO X 3. NAME OF First Middle Lost DATE Dov Year DECEASED OF DEATH WADE JANUARY 19 67 MABEL Type or print Nicate be executed IF UNDER 1 YEAR 1 IF UNDER 24 HRS. AGE (In years S. SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours 6-16-1892 WIDOWED K DIVORCED WHITE FEMALE 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY MARYLAND None 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remayal, DOROTHEA E. MC CREARY GEORGE WILLIAM VAN 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. requires that the death (Yes, no, or unknown) (If yes give wor or dotes of service MEMORIAL HOSPITAL. CUMBERLAND. ND. crematian. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (p), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) þ DUE TO signed burial Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been use as the last. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) of far use af Health CERTIFICATION NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) (County) foctory, street, office bldg., etc.) While Not While of work ot work 21. I certify that (I) (this haspital) attended the deceased fram 19___, that (I) (we) last 3 shauld M, Fram causes and an the date stated above. saw the deceased alive an. and that death accurred at 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR ATTENDING STAFF PHYS. M.D. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S BLANE SCHINDLER GREENE ST. NAME (Type) DR. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION REMOVAL (Specify) 1/16/67 Cumberland, Allegany, Md. Greenmount Cemetery 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR DATE Philip B. Wendt 121 Mem. Ave., Cumb., Md. 20 M 1/66

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY ALLEGANY ALLEGANY 3 to Page MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give neorest town) and haurs after FROSTBURG FROSTRURG d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? alang with form in Item 18. Give Pages 1, MINERS 50 OAK STREET NO X 3. NAME OF Middle First 4. DATE Lost Month Year DECEASED DEENA REENA WERNER 19 67 26 DEATH (Type or print) after (B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE X 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours WHITE 7/6/66 WIDOWED DIVORCED 24 haurs 11. BIRTHPLACE (State or foreign country) 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? AMERICA during most of working life, even if retired) INDUSTRY MARYLAND pages I NONE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within RONALD J. WERNER SALLY PAPE and 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ar removal, RBNALD J. WERNER, 50 OAK ST., FROSTBURG, MD. INTERVAL BETWEEN CHAFT AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: Asphyxiation IMMEDIATE CAUSE (o) shauld e, writing the ward farwarded ta the Cl burial, crematian, DUE TO Strangulation in Crib Conditions, if ony, which gove rise to immediate couse (o). DUE TO certificate stoting the underlying couse OS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS)
PERFORMED? YES XX NO the certificate, 20o. EXTERNAL CAUSE WAS PRIMARY

→ or CONTRIBUTING

□ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) Crib side-raid fell impinging baby's head CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 3 | 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) Not While factory, street, office bldg., etc.) may be retained tar yaur FUNERAL DIRECTOR: Page 6:30 amJan. 26 1967 of work Frostburg, Allegany, Md. ot work Home 21. I certify that I taak charge of the remains described abave, held an Autopsy (XX), Inspection X, Inquiry X, ond in my opinion Accident X Homicide | death resulted fram: Natural causes. Suicide . Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY DEPUTY MEDICAL EXAMINER XX January 26, 1967 Health ar **EXAMINER'S** BENEDICT SKITARELIC. M.D. Address (Street, city, town, or countyCumberland. Md. NAME (Type) 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 50 REMOVAL (Specify)
BURTAL 1-28-67 FINZEL CEMETERY FINZEL. GARRETT 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR VR A15ME (5) 6M 1/66 JOSEPH R. DURST, SR., FROSTBURG, MD. DATE AN



MARYLAND STATE DEPARTMENT OF HEALTH

24 hours after executed within pe certhicate The law requires that the ATTENDING PHYSICIAN: The law requires that the retained by the hospital or attending physician. O HOSPITAL VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00068 CERTIFICATE OF DEATH and in any event, within 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) filled in by the funeral papers. Pages 1 and 1. PLACE OF DEATH o COUNTY o. STATE b. COUNTY ALLEGANY MARYL AND ALL EGANY MARYLAND be executed within 24 haurs after c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, DAYS MT. SAVAGE IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS MEMORIAL HOSPITAL RT. #1. NO X 4. DATE 3. NAME OF First Middle Year CARL DECEASED WILHELM 67 JANUARY DEATH (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Hours MALE WHITE 3-31-1903 WIDOWED DIVORCED 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR GUNERY? A. during most of working life, even if retired NER BARRELVILLE, MD The law requires that the death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, ar removal, EDWARD WILHELM SARA DIEHL 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. HOSPITAL - CUMBERLAND, MD. (Yes, no, ocunknown) (If yes give wor or dotes of service) 208-09-1868 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been far use as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH be detached (IF EITHER, NOTIFY MEDICAL EXAMINER) directar, page 3 should be detache shauld be filed with the State Dept. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) 220. SIGNATURE ATTENDING STAFF M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S 4 may ST. . CUMBERLAND. MD. NAME (Type) DR. S.G. WEISMAN 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL CREMATION. BUR LAT ST. GEORGE'S CEMETERY SAVAGE. MD 2So. REC'D 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 JOSEPH R. DURST, SR., FROSTBURG, MD. DATE



| 1 | 1 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND |
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| # 120 # | | 00069 CERTIFICATE OF DEATH 00069 |
| funeral and 2 r death. | | 1. PLACE OF DEATH a. COUNTY a. STATE b. COUNTY c. COUNTY d. C |
| after y the ges 1 s after | - | b. CITY OR TOWN UP-sytside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest low |
| hours and in by rs. Page rs. Page rs. Page | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest low write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest low and give nearest low) |
| t ho led i sers. | ^^ | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| in 24 ly fille n pape Ithin 7 | 00 | 3 64 A Street & a Vale Ma 3 64 A Street YES NO S 3. NAME OF FIRST Middle Last, 14 DATE Month Day Year |
| executed within 24 hours after in and completely filled in by the farmove carbon papers. Pages 1 in any event, within 72 hours after | | 3. NAME OF DECEASED (Type or print) The state of the sta |
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com | | 5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. ACE On years IFUNDER 1 YEAR IFUNDER 2 HILL
| and remo | | Fensle While WIDOWED DIVORCED 12/8/77 89 yrs. |
| sician ease and ir | | (Oa. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR luring most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 10b. KIND OF BUSINESS OR INDUSTRY 11c. CITIZEN OF WHAT COUNTRY? |
| ficate be e g physician en please r | 1 | 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME |
| ding The | 7 | Joseph Bragg Margaret Krant |
| aw requires that the death certificate be ttending physician. has been signed by the attending physiciar as the burial-transit permit. Then please prior to burial, cremation, or removan and it | | 15. WAS DECEMBED EVER IN U.S. ARMED FORCES (16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes/no. or unknown) (If yes give war or dates of service) Mrs. Peese Hardman La Vale M2 |
| an. J by the arransit per | | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEE ONSET AND DEATH |
| es that the inysician. signed by th urial-transit urlal, cremat | 10 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION |
| es tl ohysi sign urial urial | | Conditions, If any, which by ARTERUSCLEROTIC HEART DISERSIS 10 PRS |
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| law rattend has has a | | C) |
| or a or a cate a use ealth | 2 | PERFORMED? YES NO |
| PHYSICIAN: The the hospital or a this certificate detached for use e Dept. of Health | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO [20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |
| PHYSI the h this detacl | | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 4 work 20f. (City or town) 20f. (City or t |
| oling P d by t After d be d | | |
| ATTEND retaine: CTOR: Should | 271 | 21. I certify that (I) (this hospital) attended the deceased from |
| OR ATTENT y be retaine DIRECTOR: age 3 should | | 22a. SIGNATURE 22b. DATE SIGNED |
| TAL 0 may b RAL Di , page | | 22c. PHYSICIAN'S 22d. ADDRESS |
| SPIT | / | NAME (Type) L. Michael Glick 126 N. Smallwood St. Cumberland. |
| TO HOSPITAL Page 4 may TO FUNERAL director, pa | | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (state). REMOVAL (Specify) 1 4 1 7 8 000 Hill Com- |
| , | 1 | 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE |
| VR A15 (4) | M | Laure Slein Inc. (remb. Md. DATE JAN 6 1967 Charles Judge |